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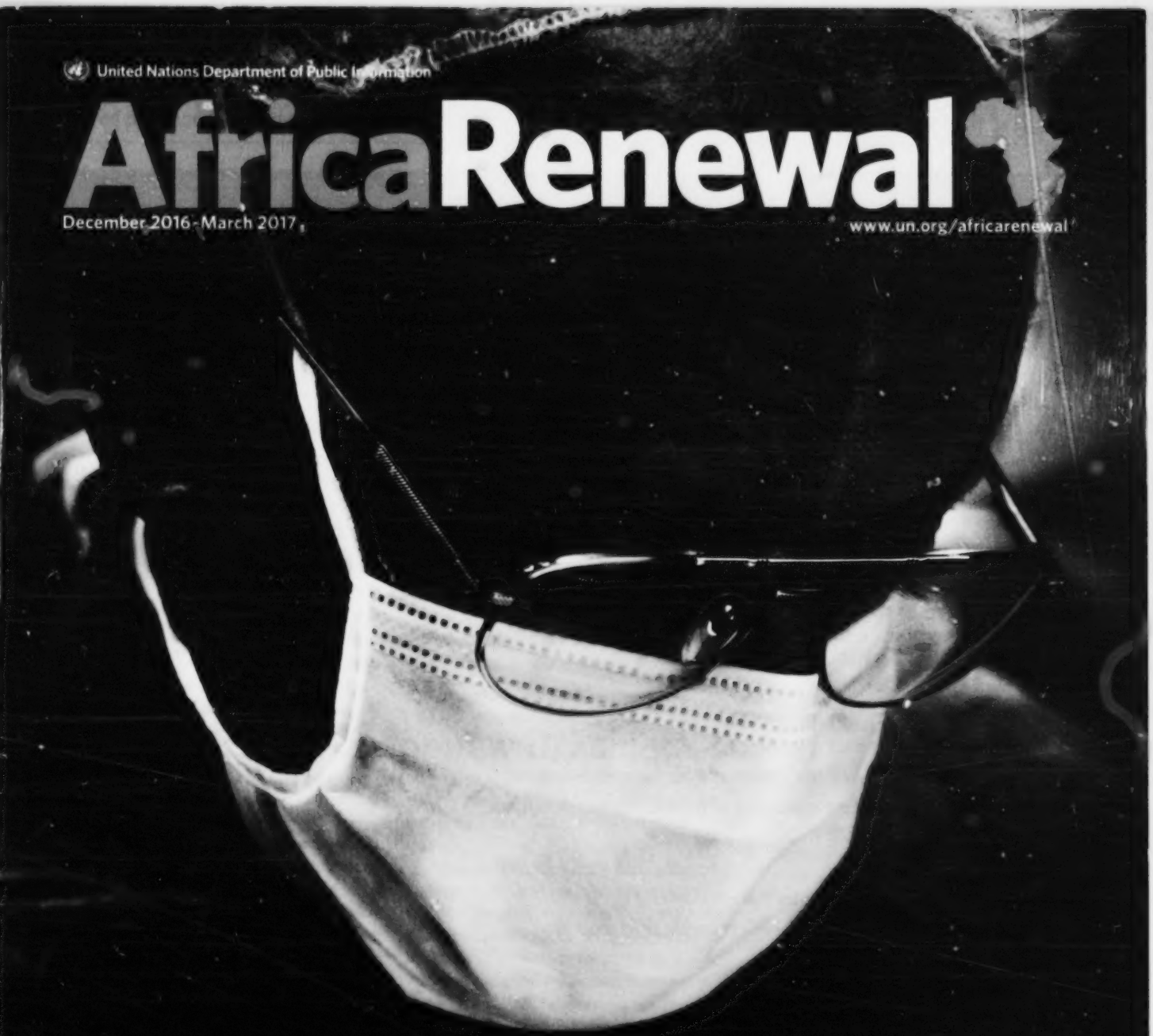

Health care systems: time for a rethink

Pain from crash in commodity prices

Migrants risk all for "better" lives

Africa's hopes for new UN chief

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Cover photo: ***A doctor examines a young girl in Nairobi, Kenya.*** *AMO/ George Philipas*

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Exercise is key to good health. *AMO/T. Omondi*

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AFRICA WATCH

Secretary-General Ban Ki-moon (right) meets with António Guterres, Secretary-General-designate.
UN Photo/Eskinder Debebe

Africa's high hopes for new UN chief

BY IHUOMA ATANGA

As the world waits in anticipation for the beginning of a new era in global diplomacy, António Manuel de Oliveira Guterres commences his term as the new Secretary-General of the United Nations.

Diplomats at UN headquarters rushed to congratulate Mr. Guterres, 67, when he was selected out of a pool of 12 candidates vying for the position last October. South Africa's ambassador, Jerry Matthews Matjila, referred to him as a "friend of Africa." Others took to social media to congratulate him.

Africa, like the rest of the world, will be watching closely as he turns his attention to issues of global peace and security, humanitarian assistance, climate change and the 17 Sustainable Development Goals (SDGs) that will drive the global development agenda in the next decade or so.

While his experience with Rwanda, South Sudan and Somalia, among other crisis regions, makes him an apt candidate for what some consider the world's most important job, the question remains: what does his appointment mean for Africa?

Born in Lisbon in 1949, Mr. Guterres has spent much of his professional life in politics and public service. Before occupying the position of Portugal's prime minister from 1995 to 2002, he held various posts within the Socialist Party from 1974 to 1995. He served as president of the Socialist International until 2005, when he was elected high commissioner for refugees (UNHCR) – head of the UN agency tasked with protecting the rights and well-being of refugees. During that time the number of people displaced by conflict and persecution rose from 38 million in 2005 to over 60 million in 2015.

As high commissioner, Mr. Guterres headed one of the world's largest humanitarian organizations, which at the end of his term had more than 10,000 staff

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QUOTABLES

UN Photo/Manuel Elías

We need to empower women. Give women a voice in the decision-making process. Give women a political voice where they can champion for their own welfare. And, of course, for us United Nations, we need to do our part.

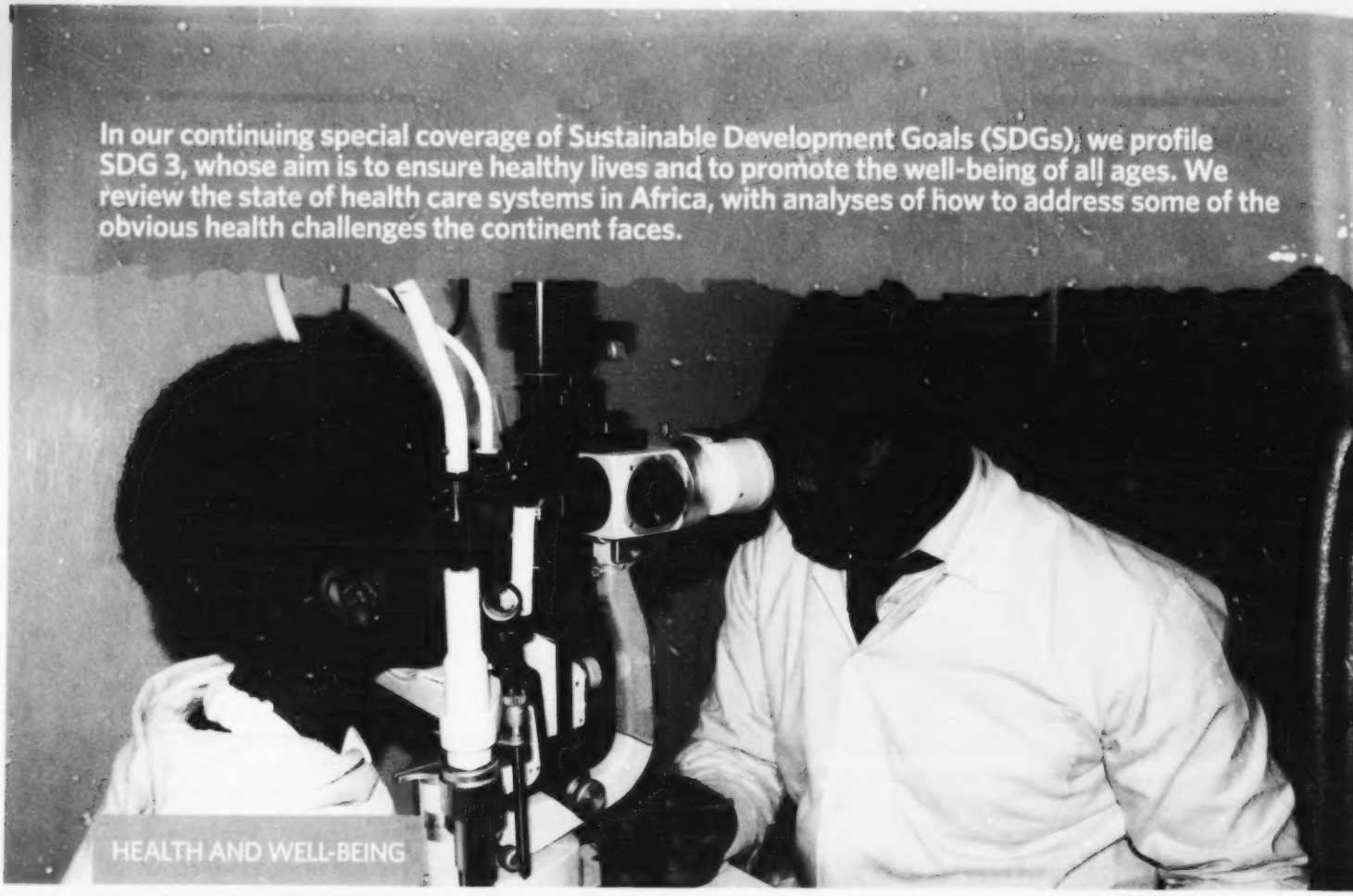
Margaret Chan, Director-General of the World Health Organization (WHO), addressing a Regional Committee for Africa in Addis Ababa, Ethiopia

Politics affect the prices in the market, the maternal mortality rate, whether our children can obtain a quality education. Politics even decide the reproductive rights of women. Therefore, we must ensure that our political representatives expand and protect our rights.

Leymah Gbowee, Liberian Nobel Peace Prize Laureate and UN development advocate in an interview with Global Education Magazine

UN Photo/Rick Bajornas

In our continuing special coverage of Sustainable Development Goals (SDGs), we profile SDG 3, whose aim is to ensure healthy lives and to promote the well-being of all ages. We review the state of health care systems in Africa, with analyses of how to address some of the obvious health challenges the continent faces.



A doctor exams a child at Rwamagana Hospital in Eastern Province, Rwanda. Rwanda Ministry of Health

Health care: from commitments to action

Governments should concentrate on providing basic health care and affordable drugs

If there is one area that vividly sums up Africa's development challenges, it is the field of health. Every year, lack of access to basic health care, mostly caused by poor funding, contributes to millions of deaths, untold suffering and harrowing health tragedies on the continent.

According to the World Health Organization (WHO), Africa carries 25% of the world's disease burden but its share of global health expenditures is less than 1%. Worse still, it manufactures only a fraction—less than 2%—of the medicines consumed on the continent. A majority of Africans, mostly the poor and those in the middle-income bracket, rely on under-funded public health facilities while a small minority has access to well-funded, quality private health care.

In 2001, African countries agreed to allocate at least 15% of their budgets to health care. Yet 15 years later, only six countries (Botswana, Burkina Faso, Malawi, Niger, Rwanda and Zambia) have met this commitment. Even in these countries, universal access to decent health care is still unrealized.

It takes a lot of ingenuity to turn the ship around. For example, Rwanda has managed to setup a national health insurance scheme which now covers 91% of all Rwandans. This is in sharp contrast to other African countries where medical insurance schemes cover, on average, less than 8% of the population, according to WHO.

There are a few bright spots in fighting some diseases. Africa is finally making headway in the fight against malaria, the leading cause of deaths in the region. WHO announced last year that the global incidence of malaria had finally been slowed, largely due to a massive rollout of mosquito nets, anti-malaria medicines and use of insecticides.

Over the past decade, thanks to heightened emphasis on prevention, treatment and care, the rate of new HIV infections is slowing down as more infected people are receiving antiretroviral drugs.

Africa's key challenge, however, is confronting what still needs to be done. Governments should concentrate on providing access to basic health care and affordable drugs, training more community health workers and extending medical insurance coverage through creative partnerships with the private sector.

Gains made in fight against malaria

Africa is finally making headway in its decades-long fight against malaria

BY **AMELIA TAN**

The World Health Organization (WHO) announced in December 2015 that the global incidence of malaria had finally been slowed, thanks in large part to a massive rollout of mosquito nets, antimalaria medicines and indoor residual spraying of insecticides. The news was particularly welcome in Africa, where the disease has been the deadliest.

Malaria is caused by parasites that are transmitted to people through the bites of infected female anopheles mosquitoes.

Between 2000 and 2015, malaria mortality rates in Africa fell by 66% among all age groups. Among children under five, who are the most vulnerable to the disease, fatalities fell by 71%, from 694,000 to 292,000 deaths, during the same period.

Progress in the use of mosquito nets has been impressive. WHO data shows that in 2000, just 2% of the 667 million people living in sub-Saharan Africa at that time slept under mosquito nets. By 2015, more than half of Africa's 1 billion people were using bed nets.

In addition, Margaret Chan, the director-general of WHO, wrote in the foreword of the *World Malaria Report 2015* that "a rapid expansion in diagnostic testing and the availability of antimalarial medicines has allowed many more people to benefit from timely and appropriate treatment."

A nurse takes blood sample from a baby to test for malaria in Manhia, Mozambique. AMO/L W

A coordinated approach

Efforts to prevent malaria have also resulted in significant health care cost savings. Sub-Saharan countries saved up to $900 million on the costs of malaria case management between 2001 and 2014, notes the world health body. Mosquito nets represented the biggest cost savings, followed by artemisinin-based combination drug therapies (ACTs) and indoor residual spraying.

An ACT consists of an artemisinin-based compound combined with a drug from a different class. Medical experts recommend the use of a combination of drugs because using one drug can speed up the development of drug resistance in parasites.

Much progress in the malaria fight has been the result of global partnerships and funding schemes established in 2000. A notable partnership is the Roll Back Malaria (RBM) initiative, which was set up by WHO, the United Nations Children's Fund (UNICEF), the UN Development Programme (UNDP) and the World Bank. Under the RBM, over 500 development groups, private- and public-sector organizations and research and academic institutions have pooled their resources and expertise to fight the disease.

High-profile partnerships are effective, as they put pressure on governments to fight diseases, stated the Centers for Disease Control and Prevention (CDC), an American public health institute, in a 2011 report.

The report commended leaders in malaria-endemic countries for their commitment to treating malaria control as a national priority, as they agreed to do under the 2001 Abuja Declaration and Frameworks for Action on Roll Back Malaria and the UN Millennium Development Goals.

Funding for malaria programmes has reached unprecedented levels. Money has come in through schemes such as the US President's Malaria Initiative and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Global financing for malaria control increased from $960 million in 2005 to $2.5 billion in 2014, according to WHO's *World Malaria Report 2015*.

The road to elimination

Yet despite recent progress the fight is far from over. Africa, the epicentre of the disease, is still vulnerable. Last year 88% of the 214 million cases and 90% of the 438,000 malaria deaths reported worldwide occurred in the WHO African region. The region includes Algeria but excludes Sudan and Somalia.

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It's time to rethink medical insurance

A mobile phone plan in Kenya targets low-income groups

BY **MASIMBA TAFIRENYIKA**

"If we can get cold Coca-Cola and beer to every remote corner of Africa, it should not be impossible to do the same with drugs," the late Dr. Joep Lange, a pioneering researcher in HIV/AIDS treatment in Africa in the late 1990s, once declared.

In 2000 Dr. Lange founded the PharmAccess Foundation to make HIV/AIDS treatment accessible in Africa through partnerships with multinational companies operating in the region. His first success story was to convince Heineken, a Dutch brewing company, to provide HIV treatment to its employees in Africa.

When it was started, PharmAccess, based in Amsterdam, focused on delivering lifesaving drugs to HIV patients. Today the group, through private companies, runs small but fast-growing medical insurance schemes for the poor in several African countries. It is active in Ghana, Kenya, Namibia, Nigeria and Tanzania, where it offers health insurance through private-public partnerships.

Africa's health system is appalling. Only an overhaul could move it closer to United Nations Sustainable Development Goal Number 3 ensuring healthy lives and promoting well-being for all.

Access to decent health care is a daily struggle for the sick, due to seriously underfunded national health systems, lack of basic infrastructure to provide clean water and electricity and a serious shortage of health care workers. The Ebola outbreak, which ought to be a wake-up call, exposed the soft underbelly of the continent's flawed health systems.

The statistics paint a grim picture. The World Health Organization (WHO), a global health body, reckons Africa bears a quarter of "the global burden of diseases but has access to only 3% of health workers and less than 1% of the world's financial resources." Barely a handful of African countries have met their pledge—made to the African Union—to pump at least 15% of their national budgets into health care.

A coffee farmer from Musasa, Rwanda, shows her health insurance card. Panos/Andrew Esiebo

In countries where one can get decent public health care, it comes at a price the majority can hardly afford. In some cases a two-tier system gives the rich access to quality care through private health insurance while the rest have to put up with overcrowded state-run facilities where they pay out of pocket.

Out-of-pocket payments

Regrettably, things are worsening. The World Bank reckons the share of out-of-pocket health payments as a portion of all health expenditures in sub-Saharan Africa rose from 40% in 2000 to over 60% in 2014. The effect of out-of-pocket payments can be catastrophic to families; it drags them into a poverty trap.

In the few African countries where national medical insurance schemes exist, they serve only a minority, according to WHO. In Ghana, WHO says, only a third of the population receives medical insurance under the country's National Health Insurance Scheme. Nigeria's national scheme covers less than 3% of its citizens.

South Africa spends more on voluntary private health insurance as a share of total health expenditure (42%) than any other country in the world, says WHO. Yet this scheme covers only 16% of the population. The country, which has unequal access to health care among different socioeconomic groups, has started rolling out a single National Health Insurance System that will provide free health care to all South Africans.

Rwanda is Africa's trailblazer in providing universal health insurance. Its community-based national plan coverage rate is the highest on the continent. The plan, called *Mutuelles de santé* (Mutual Health), covers 91% of the population. To reach this level, Rwanda trained thousands of community health workers—45,000 to date. While health insurance is financed by both government and individual premiums, donors fund about half of Rwanda's health budget. "The most hard-up [Rwandans] pay nothing for membership in the programme, [while] wealthier folks pay about $8 a year,"

says *The Economist*, a UK weekly. "Visits to doctors then cost just 30 cents or so." This is remarkable for a country whose national income, at $692, is one of the lowest in the world.

To reverse current trends, experts maintain that the private sector should take the lead in offering affordable prepaid insurance coverage, mostly to low-income families. McKinsey, a global strategic management consultancy firm based in the United States, says the market for health care in Africa is worth about $35 billion.

Embracing a new approach

An award-winning essay, "A New Paradigm for Increased Access to Healthcare in Africa," by PharmAccess's Dr. Lange and three other medical experts—Dr. Onno P. Schellekens, Dr. Marianne E. Linder and Prof. Jacques van der Gaag—argues that it is time to rethink the way health care is delivered in poor countries. While it's an old essay (it was published in 2007), its innovative health care financing model is starting to bear fruit where it's being applied. The essay won the World Bank's International Finance Corporation/*Financial Times* essay competition in 2008 and the G20 Financial Challenge Award in 2010.

The key message from the essay is that instead of focusing on governments as the major financers and providers of health care, the priority should be to encourage private-sector initiatives whose goal is "to provide affordable access to high quality health care for low-income households." The authors outline a three-step strategy they say is "essential to develop[ing] viable health systems" that expand access in poor countries.

The first step is to target those who can pay and then align the demand and supply of health care through prepay arrangements, the same practice that has successfully transformed mobile phone companies in Africa. The second is to set up risk-pooling schemes from existing out-of-pocket payments that will lower costs, raise quality, increase willingness to pay and boost contributed funds. The final step is to enforce quality standards in countries with weak regulations.

Now, this would all sound theoretical were it not for the fact that PharmAccess is implementing this model in Kenya, Namibia, Nigeria, Tanzania and Uganda. The scheme is still in the early stages but rapidly gaining popularity with both health care beneficiaries and providers.

In 2013, PharmAccess launched the mHealth mobile health wallet. The wallet, which runs on a mobile phone, is used solely to pay for health expenses. The pilot plan targeted 5,000 mothers with children under the age of five living in informal settlements in the Kenyan capital, Nairobi. Users received a thousand Kenyan shillings (US$10) in their wallets. The project scored a 90% success rate when the women responded positively to a survey, with more than three-quarters expressing willingness to save their own money for health in the wallet.

$35 billion
is the value of the health market in Africa, according to McKinsey

Success with partnerships

Two years later, following the success of the pilot project, PharmAccess partnered with Safaricom, Kenya's largest mobile telecom, and M-Pesa, a mobile money transfer service, to launch a mobile health wallet called M-Tiba (*m* stands for "mobile" and *tiba* means "medical treatment" in Swahili). M-Tiba allows users to save money in their mobile phones to pay for medical services at designated medical facilities.

In October 2016, PharmAccess rolled out M-Tiba nationwide, targeting low-income Kenyans. So far M-Tiba has over 100,000 registered users with access to 120 health care providers in Nairobi and some areas outside the city.

"If there is any innovative event happening on the continent that is leading us towards the attainment of universal health coverage, then it is M-Tiba," Khama Rogo, the head of the World Bank's Health in Africa Initiative, noted. "M-Tiba is truly leapfrogging health care in Kenya."

M-Tiba offers several advantages. Users can save money for their own health care, or receive contributions from friends and relatives or other payers such as governments or charity organizations. The system gives donors access through M-Tiba "to the poor at virtually no cost to provide health entitlements such as vouchers to vaccinate children." It gives health care providers access to real-time digital payments with medical and financial data collection. Doctors receive their payments on time and it's relatively cheap to run.

Denying treatment

According to Nicole Spieker, the quality director at PharmAccess, the company is collaborating with companies and governments in Nigeria and Tanzania on prepaid health care schemes for the poor. She told *Africa Renewal* in an e-mail that more than 200,000 people have so far signed up with the Kwara State Health Insurance Programme in Nigeria and the improved Community Health Fund (iCHF) in Tanzania.

Analysts say the private health insurance industry—in partnership with governments and taking advantage of technology—can transform health systems in Africa. But critics warn that if not properly regulated, the industry can enrich insurance owners while denying or restricting treatment to patients. If unchecked, companies could be lax in preventing fraud and waste and keeping down costs, critics say. They can select the diseases they will cover, or avoid enlisting sick people, or deny treatment whenever they can.

If there is any innovative event happening on the continent that is leading us towards the attainment of universal health coverage, then it is M-Tiba. M-Tiba is truly leapfrogging health care in Kenya.

The old system, whereby governments crowd out the private sector, has brought Africa to its current state. It is time to try new ideas that give more space to public-private entities that can provide the poor with greater access to health care.

Diagnosing Africa's medical brain drain

Higher wages and modern facilities are magnets for Africa's health workers

BY **KINGSLEY IGHOBOR**

Medical students watch as doctors perform an operation in Moshi, Tanzania. Panos/ Sven Torfinn

Dressed in full medical gear and clutching a folder, Folu Songonuga, a physiotherapist, walked briskly across the lobby in the offices of Activa Rehabilitation Services in Orange, New Jersey, United States. An elderly man, evidently in pain, had just been wheeled into an inner room, and Dr. Songonuga was on his way to tend to the patient.

"I see up to 20 patients a day," Dr. Songonuga, a Nigerian by birth but now a naturalized American, told *Africa Renewal*. Together with his compatriot Olufemi Dosumu he owns the rehabilitation business, established in 1996, and they plan to expand to other states.

Dr. Songonuga obtained a bachelor's degree from Obafemi Awolowo University in western Nigeria before migrating to the United States, where he later bagged a doctorate in physiotherapy. He is one of thousands of Nigerian health workers based in the US.

With the incentive of higher pay and modern facilities, Africa's top doctors, like Dr. Songonuga, stream overseas in search of greener pastures.

"I left Nigeria because I wanted to earn more money, learn new things and to practise in a better environment," he said.

On average, surgeons in New Jersey earn $216,000 annually, while their counterparts in Zambia make $24,000. Kenyan doctors earn on average $6,000 per annum.

Osahon Enabulele, a former president of the Nigerian Medical Association, estimates there are about 8,000 Nigerian doctors in the United States. Yet in their motherland, only about 35,000 doctors attend to the country's 173 million citizens, according to Folashade Ogunsola, a professor of medicine and chairman of the Association of Colleges of Medicine of Nigeria.

The World Health Organization (WHO), the UN body responsible for promoting international public health, puts Nigeria's doctor-to-population ratio at 0.3 per 1,000 persons, which is grossly inadequate. The country needs at least 237,000 doctors, says Dr. Enabulele.

According to 2015 WHO data, the doctor-to-population ratio in Liberia and Sierra Leone (two countries recently hit by the Ebola epidemic) is even worse: 51 doctors for Liberia's population of 4.5 million (0.1 per 1,000 people) and 136 doctors for Sierra Leone's 6 million people (0.2 per 1,000). Ethiopia has 0.2 doctors per 1,000 and Uganda has 0.12 doctors per 1,000 inhabitants, while South Africa and Egypt, at 4.3 and 2.8 per 1,000 respectively, have better ratios.

In search of greener pastures

"About 44% of WHO member states have less than one doctor per 1,000 population," reported the health body in 2015. "Countries with the lowest relative need have the highest numbers of health workers, while those with the greatest burden of disease must make do with a much smaller health workforce."

Africa bears "more than 24% of the global burden of disease, but has access to only 3% of health workers and less than 1% of the world's financial resources," according to WHO.

The poor state of health systems in many African countries is another red flag to medical professionals. Even before Ebola hit Guinea, Liberia and Sierra Leone in 2014, up to 57% of facilities in these countries were in poor condition, with "poor service readiness," meaning "lack of diagnostics and essential medicines in many facilities," noted WHO.

Despite the critical need for doctors, the government of Uganda recently approved a plan to recruit over 200 doctors and nurses to Trinidad and Tobago. The Ugandan government promoted the initiative, maintaining that it could "further accelerate the existing excellent bilateral relations." The Caribbean country has provided financial aid and training for Uganda's oil and gas industry and its police force in the past.

But a local think tank, the Institute of Public Policy Research Uganda (IPPR-U), challenged the wisdom of the government's move. "While the government is bent on exporting health workers, thousands of Ugandans are dying daily," the group said. "Sixteen women die daily giving birth." The think tank took the matter to court, accusing the government of violating "the constitutional rights of Ugandans to access basic medical services."

The court ruled against the IPPR-U, but not before the think tank drew attention to the precarious state of Uganda's health care system.

Similarly, last year five of the six doctors working in Kenya's Lamu County resigned, leaving just one to tend more than 100,000 county citizens. The doctors complained of low wages, poor working conditions and insecurity; some wanted to go into private practice while others planned to move to South Africa or elsewhere.

Financial losses mount

Countries that invest in the training of health workers suffer financial losses when these educated professionals emigrate, according to a 2011 research by a group of Canadian scientists led by Edward Mills, chair of global health at the University of Ottawa. The researchers studied nine sub-Saharan African countries (Ethiopia, Kenya, Malawi, Nigeria, South Africa, Tanzania, Uganda, Zambia and Zimbabwe) and estimated that these countries suffered a loss of about $2.1 billion from investments for all doctors working in destination countries up to 2010. It costs African nations between $21,000 and $59,000 to train each doctor, the Canadian team found.

Africa's loss is rich countries' gain: the research estimated that financial benefits amounted to $2.7 billion to the UK, $846 million to the United States, $621 million to Australia and $384 million to Canada. Rich countries should provide financial and logistical support to Africa's health institutions, the researchers recommended.

Five years ago the United States provided $130 million for training in 13 medical schools in sub-Saharan Africa, including the University of Zambia, the University of Zimbabwe, the University of Botswana, Nigeria's University of Ibadan and Ghana's Kwame Nkrumah University of Science and Technology. The money would also benefit about 20 American medical schools that have agreed to collaborate with the African universities in this programme. Non-governmental organizations such as the Bill & Melinda Gates Foundation are also funding health programmes across the continent.

Is brain drain a crime?

Some African and Western aid workers have referred to Africa's medical brain drain as a crime, stirring a debate on the morality and legality of international medical recruitment.

In a 2011 article published by *The Lancet*, a British medical journal, the aid workers wrote, "High-income countries, such as Australia, Canada, Saudi Arabia, the US, the United Arab Emirates, and the UK have sustained their relatively high physician-to-population ratio by recruiting medical graduates from developing regions, including countries in sub-Saharan Africa.

In contrast, more than a half of the countries in sub-Saharan Africa do not meet the minimum acceptable physician-to-population ratio of 1-per-5,000 WHO standard."

WHO's code of practice on international recruitment of health care workers, adopted in 2010, in an attempt to tackle problems caused by medical brain drain, urged wealthy nations to support affected countries; however, the code is a moral guide rather than an enforceable legal instrument.

In April 2001, heads of state of African Union countries met and pledged to allocate at least 15% of their annual budgets to improving the health sector. At the same time, they urged donor countries to "fulfil the yet to be met target of 0.7% of their GNP as Official Development Assistance (ODA) to developing countries."

Twelve years later, only six countries (Liberia, Madagascar, Malawi, Rwanda, Togo and Zambia) had hit that target. The majority of the countries performed poorly, blaming lack of adequate financial resources and competing domestic priorities for the failure.

Kasonde Bowa, a professor of urology and dean of Copperbelt University School of Medicine in Ndola, Zambia, told *Africa Renewal* that medical brain drain can be tackled with improved remuneration and investments in postgraduate training, because "it is very easy for doctors who train abroad to remain abroad." US law, for instance, allows foreign medical students to remain in the United States if they agree to work in rural areas. The UK and other countries also regularly make it easier for health care workers to get work permits than for others.

Stemming the flow of talent

Dr. Bowa studied in Scotland, and, unlike others who stayed after completing their studies, he returned to Zambia to practise and teach. "I didn't go to Scotland on my own; I was sponsored and I had an obligation to come back," he said.

Dr. Bowa calls for investment in modern equipment for medical facilities, particularly hospitals, as well as incentives such as access to housing and land and a clear-cut career path for health workers, especially those in rural areas. "They must have an opportunity to rise."

Indications are that demand for health workers in Australia, Canada, the UK, the United States and other rich countries will continue to rise. The US Council on Physician and Nurse Supply estimates a shortage of 200,000 doctors between 2012 and 2022.

Laurie Garrett, a senior fellow at the US Council on Foreign Relations, concurs: "For the foreseeable future, every health provider [in the United States], from Harvard University's health facilities all the way down to a rural clinic in the Ethiopian desert, is competing for medical talent, and the winners are those with money."

A health worker from a poor country is good "for a diabetic or someone with heart disease in rural Nebraska," writes Matt McAllester, a *New York Times* editor. "[Patients] may be unaware, however, that their gain is a poor country's loss."

The loss could well be the lives of hundreds of diabetic patients in Africa's villages.

Lifestyle diseases pose new burden for Africa

Diabetes, cancer, heart and respiratory diseases will be the leading killers by 2030

BY **ZIPPORAH MUSAU**

A Virgin Active gym in Soweto, Johannesburg South Africa. AMO/Robert Tshabalala

Anxiety grips Jennifer Nakazi as her phone beeps for the third time since she arrived at a busy bank lobby in downtown New York. She's going to wire money to her family in Uganda. Her brother is calling with the latest update on their critically ill mother.

After battling diabetes for almost a decade now, the 63-year-old matriarch has just been hospitalized after her blood sugar level hit a record high. Her blood pressure also shot up, raising fears she could also be hypertensive.

"I hope we don't lose our mother. It is not even two years since our father succumbed to diabetes. It's a difficult time for us," Ms. Nakazi tells *Africa Renewal*. She finally returns her brother's call after wiring some $700. Their mother's condition has stabilized and they are all relieved, but they know the struggle is far from over.

Ms. Nakazi, 26, is careful about her selection of food, avoiding sugar and alcoholic drinks. She fears succumbing to diabetes or one of the other relatively new diseases on the continent whose numbers have more than doubled in recent years.

Diabetes type 2 falls in the category of non-communicable diseases (NCDs), along with cardiovascular diseases, cancer and chronic respiratory diseases often referred to as "lifestyle diseases" because they are largely linked to the way people live their lives and to surrounding environmental factors.

The four key risk factors for these diseases are unhealthy diets (foods high in fats, sugar or salt), tobacco use, harmful use of alcohol and physical inactivity.

These behaviours set the stage for later development of lifestyle diseases such as high blood pressure, overweight, respiratory diseases, high blood sugar and high cholesterol levels.

It is during adolescence or adulthood that these risky behaviours are typically established, experts say, and they are easily modifiable. Millions of lives could be saved by healthy diets, exercise and the avoidance of tobacco and alcohol. It is a path Ms. Nakazi is determined to take.

NCDs are now the leading cause of death in most regions of the world, accounting for up to 70% of all deaths worldwide, according to the World Health Organization (WHO). In 2012, for example, the diseases killed 38 million people, of whom 80% were from developing countries, including those in Africa. About half of these people died prematurely—before the age of 70.

Long considered diseases of the West and often associated with the urban and affluent in society, NCDs have crept silently into many corners in Africa, remaining relatively unnoticed as governments and the international community focus on combating communicable diseases such as malaria, tuberculosis, polio and HIV/AIDS.

Time bomb

Africa, home to 54 low and middle-income countries, will have the world's largest increase in NCD deaths over the next decade. Although communicable diseases such as malaria, TB and HIV/AIDS and other conditions still predominate in sub-Saharan Africa, WHO projects that, by 2030, NCDs will become the leading cause of death. This would impose a significant burden on the continent, whose population will double within the next generation.

"In Africa, NCDs are rising rapidly and are projected to exceed communicable, maternal, perinatal and nutritional diseases as the most common causes of death by 2030," Dr. Oleg Chestnov, the assistant director-general for non-communicable diseases and mental health at WHO, told *Africa Renewal*.

In North Africa, NCDs are already responsible for more than three-quarters of all deaths, and nearly half the population in this region already suffers from hypertension (high blood pressure), a well-established precursor to NCDs such as heart diseases, according to the WHO's non-communicable diseases country profiles for 2014. In Algeria, Egypt, Libya and Morocco, for example, more than 75% of all deaths in 2012 were due to NCDs.

Of immediate concern to public health planners is that 30% of all people in Africa have high blood pressure (above 140/90 mmHg millimetres of mercury – the unit measurement of blood pressure) and will most likely suffer from coronary heart diseases, stroke, renal or visual impairment or other related conditions.

Negative effects

The effects of these diseases are as devastating to the economy as they are to the people they afflict. At the national level, they impede efforts to fight poverty, making it difficult to achieve global development goals such as the Sustainable

Development Goal (SDG) number three, which aims to ensure healthy lives and to promote the well-being of all people.

At a broader level, widespread chronic illness translates into decreased labour outputs, lower returns on human capital investments and increased health care costs.

In addition, the rise in NCDs will create what's called a "multiple burden of disease" for already overstretched health systems, particularly in Africa, where communicable diseases such as malaria, TB and HIV/AIDS, as well as poor maternal and child health, remain a major problem. Treating people with NCDs is complex — involving advanced diagnostics and drugs, as well as intensive disability management and prolonged care.

An ounce of prevention

Although tobacco use is the single most preventable cause of disease, disability and death in the world, more and more young people in Africa are taking up the habit.

"About one in 10 adolescents in Africa smokes cigarettes and the same proportion use other tobacco products such as chewing tobacco, snuff, or pipes. A half of all adolescents in Africa are exposed to secondhand smoke," says the Washington, D.C.–based Population Reference Bureau (PRB), a nonprofit research organization.

In Zambia, for example, about one-quarter of secondary school students aged 13 to 15 either smoke or use other tobacco products. In South Africa, the RPB report says, 24% of boys and 19% of girls in secondary school use tobacco.

As for alcohol, heavy marketing in African countries and the portrayal of alcohol use as "cool" in many colourful advertisements, along with its easy accessibility, have exposed more youths to the vice. About 26% of boys and 21% of girls aged 13 to 15 in Namibia are current alcohol users. In Mauritius, 21% of boys and 14 % of girls in secondary school reported having been excessively drunk one or more times during their life.

Way forward

To curb this lifestyle epidemic requires global, national and individual commitment. Globally, WHO is mobilizing countries for collective action, especially African countries, many of which have inadequate NCD interventions.

Under the SDGs adopted by UN member states in 2015, global leaders committed to an NCD target of reducing premature deaths caused by lifestyle diseases by 30% by 2030. They committed to national NCD reduction targets and to developing national policies and plans to achieve their goals, such as plans to reduce exposure to factors that put people at risk of the diseases and to strengthen health systems to cope with them.

Some of the options that WHO is promoting to reduce lifestyle diseases are raising taxes and prices on tobacco products, implementing plain packaging or comprehensive bans on tobacco packaging designed to attract consumers, increasing taxation on alcoholic beverages and enforcing bans on alcohol advertising.

Diet-related options include compelling companies to reformulate their food products to contain less salt to protect people from cardiovascular disease, and taxing sugary drinks, one of the main causes of the global epidemics of obesity and diabetes.

Health systems can also provide essential drug therapies and counselling to people who have had a heart attack or stroke, or for people at higher risk of cardiovascular disease. Also, proven measures, such as vaccination against the human papilloma virus (HPV), can prevent nearly all cases of cervical cancer, which kills many women in Africa each year.

So far there has been some progress, according to Dr. Chestnov. To date, 60% of countries globally have set targets to fight NCDs, while 92% have since integrated responses to NCDs into their national health plans. Others are trying to tax tobacco products to get financing for public health, but it is still a work in progress.

The simplest and cheapest means of preventing and controlling these diseases is for individuals to make good lifestyle choices by opting for healthy diets (lots of vegetables and fruits and less sugar, salt and fats), avoiding tobacco and alcohol, and exercising.

Unless urgent action is taken, the growing NCD epidemic will add tremendous pressure to already overstretched health systems and pose a major challenge to development in Africa.

All in all, a rising NCD epidemic will require more resources for strengthening and adapting health systems. Given that the rates of social and economic growth in the African region are unlikely to keep pace with the rapid rise of NCDs, taking urgent preventive action now will be far less challenging than waiting to address a costly full-fledged NCD epidemic.

Fighting NCDs

Raise taxes on alcohol and tobacco to finance public health

Enforce ban on alcohol advertising

Reduce salt in food products

Increase taxes on sugary drinks

Make essential drug therapies easily available

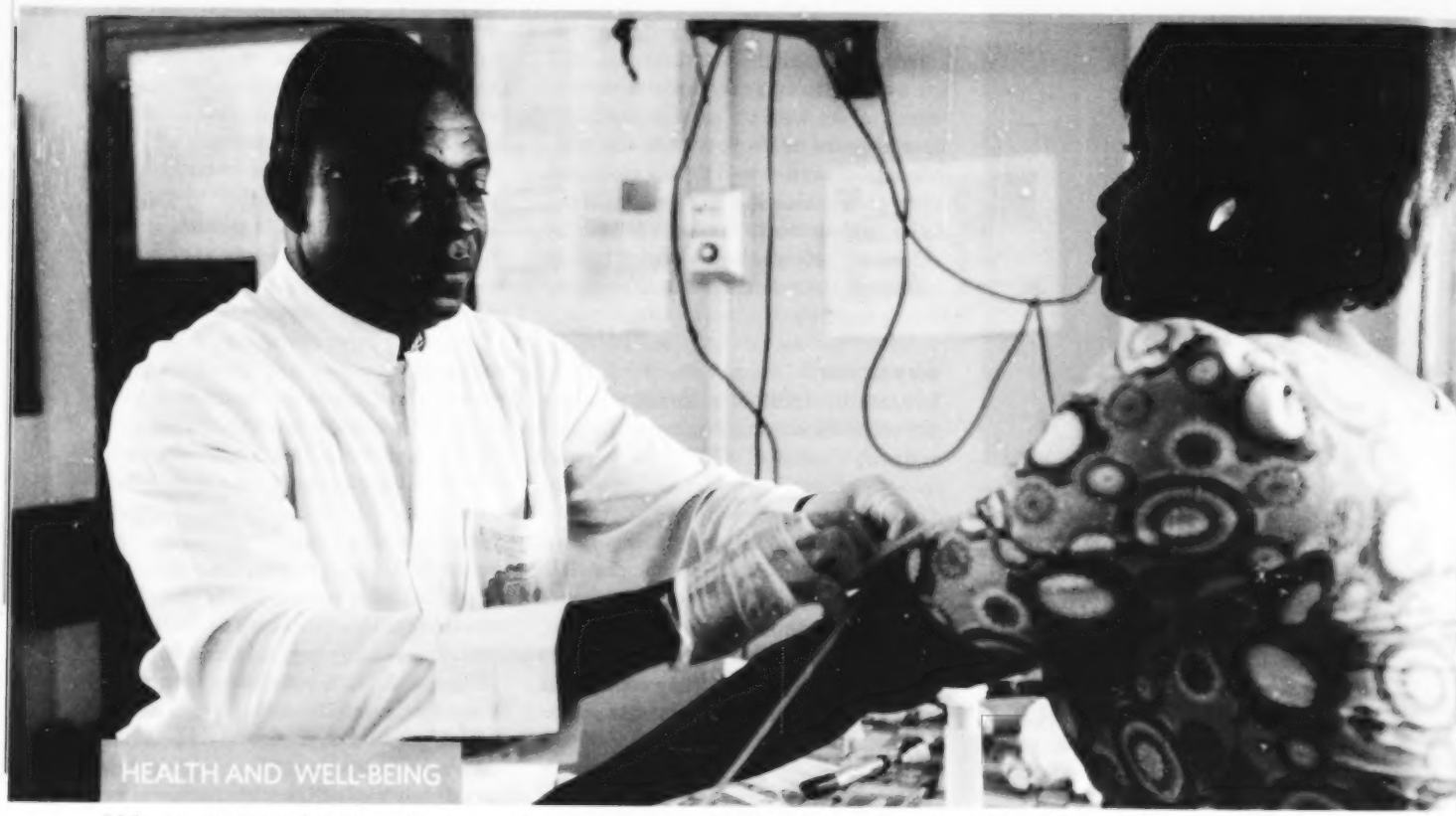
Encourage physical and other outdoor activities

Promote healthy diets, with lots of fruits and vegetables

Public health schemes: Getting it right

Ghana grapples with making health care universally accessible

BY **FRANCK KUWONU**



A laboratory studies student taking a blood sample for a routine antenatal malaria test at a government hospital in Ghana. Panos/Nyani Quarmyne

When Bernard Natey could not find a qualified cardiac surgeon in his native Togo to implant a pacemaker in his heart to manage an irregular heartbeat, he promptly packed his bags for a hospital stay in neighbouring Ghana.

In the capital, Accra, Mr. Natey told *Africa Renewal* that he planned to have the procedure at Korle-Bu Teaching Hospital, the leading public hospital in Ghana, which offers advanced and specialized care that is rarely available in other West African health care institutions.

The hospital prides itself on its ability to attract a sizeable number of its clientele from neighbouring countries such as Burkina Faso, Nigeria and Togo because of its expertise in plastic and reconstructive surgery, burn treatments, cardiothoracic and radiotherapy services and nuclear medicine, among others.

Mr. Natey's experience is typical of people across sub-Saharan Africa who need medical care but are unable to get it in their home country because of either unavailability or prohibitive costs.

Almost half of people interviewed in 36 African countries told Afrobarometer, an independent pan-African research network that conducts public opinion surveys, that they had not had access to necessary medical care in either 2014 or 2015, while 4 out of 10 had found it "difficult" or "very difficult" to access needed care during that time.

Across West Africa, such is the dilemma of many seeking quality health care. Citizens of Côte d'Ivoire, Gambia, Liberia and Sierra Leone can regularly be found traveling to Ghana for treatment.

But what is it about Ghana's health care that draws both Ghanaians and outsiders?

Guaranteed access

The answer is availability and affordability. To make health care affordable to all, Ghana was one of the earliest African countries to introduce a universal health insurance system — the National Health Insurance Scheme (NHIS).

The country is currently implementing a private-public partnership programme

that allows a network of private facilities to provide health care in areas without public health services. Although it faces challenges, this programme has been applauded internationally, including by the United Nations and the World Bank, as a model for sub-Saharan Africa in addressing the challenges facing its public health systems.

The government-sponsored NHIS is funded mainly through taxation on selected goods and services. It covers treatment for the most prevalent diseases in the country, including malaria, skin diseases, stomach disorders, hypertension, diabetes, asthma, eye and ear infections, rheumatism and typhoid, and also covers dental care.

Under the law, all residents are required to enrol and, unless they are in one of the exempted groups, pay annual premiums. In return they are not expected to make additional out-of-pocket payments when they require care.

The scheme has gone through reforms since it was formally launched in 2004. In 2011 the NHIS was recognized by the UN Development Programme (UNDP) and the World Health Organization (WHO) for "improving financial access to health care services, particularly for the poor and marginalized."

NHIS had an active membership of more than 10 million people in 2013, estimated to be about 38% of the entire population. According to Afrobarometer's ranking of countries by percentage of citizens without access to health care, Ghana had the fourth-lowest percentage (26%) over the past two years, just behind Algeria (25%), Cape Verde (19%) and Mauritius (2%).

Ghana's performance may be attributed to the impact of the insurance scheme. A study on the impact of the NHIS on the use of health care, published in the *Ghana Medical Journal* in 2012, showed that people with health insurance were likely to obtain prescriptions, visit clinics and seek formal health care when sick. The authors said, "Ghana government's objective to increase access to the formal health care sector through health insurance has at least partially been achieved."

Another reason for the high use of health care is the way the government relies on the private sector to provide access. Ghana is "ahead of many other [African] countries" because it has a specific policy on the role of the private sector in health, the World Bank said in its working paper, *Private Health Sector Assessment in Ghana.*

For example, the government entered into partnership with the Christian Health Association of Ghana (CHAG), a network of 183 Christian faith-based care providers, to offer health services in underserved areas. Under the accord, the government provides support to the network facilities in the form of salaries, equipment and supplies. As CHAG members operate in remote areas across the country, serving underprivileged communities, their network allows the government to extend health care to areas with no public facilities.

"The public-private partnership between the ministry of health and CHAG is unique in sub-Saharan Africa and works well, allowing CHAG to act as an extension of the government, particularly in underserved rural areas," the World Bank report concluded.

Growing pains

However, it has not been all smooth sailing for the NHIS since its launch over a decade ago. The scheme appears to be going through growing pains. According to the government's own estimates, only a little more than 38% of the population is enrolled, while hospitals are still asking some of those insured to pay for their care out of their pockets. Health care providers have repeatedly complained about not being reimbursed fast enough.

Also, while the insurance is mandatory for all residents of Ghana and is financed by premiums from subscribers—2.5% national health insurance levy, 2.5% social security and national insurance trust, deductions from the formal sector, funds from the government, charities, and returns from investment—still experts say the scheme has been underfunded since 2009.

The National Health Insurance Authority, which administers NHIS, notes on its website that 69% of those insured are exempt from paying premiums. Those exempted include people below 18 or over 70 years, pregnant women, the needy and those who belong to specific disability categories.

The agency recognises that the cost of providing care has risen much faster than available financial resources since the scheme became operational in 2005, which has created persistent and growing annual deficits over the past several years.

As Ghana prepares for general elections in December 2016, sustainability of the health insurance scheme has become a point of contention between the main political parties. The main opposition party argues that the scheme is dead but promises to revive it if elected, while the governing party points to the country-wide drive to have members of the medical scheme renew their annual membership as a measure of the scheme's success. Beyond the political banter, however, most Ghanaians appear to agree on the need for reforms.

In an effort to address the scheme's sustainability, a commissioned government review has proposed reining in costs by limiting coverage to primary, maternal and child care.

"NHIS should be re-prioritized towards universal access to primary health care in the medium term, and progressive realization of universal access to higher levels of care in the long term," the review committee recommended in April.

Even as the country grapples with its insurance scheme's sustainability and, at times, with unreliable services in public facilities, Korle-Bu, the main public hospital in Accra, continues to attract patients from outside the country because of its reputation for advanced and innovative care.

By the numbers

69%
of insured Ghanaians are not required to pay premiums

38%
of the population covered by insurance

26%
of Ghanaians didn't have access to health care in 2015

We can improve health systems in Africa

— Dr. Matshidiso Moeti

Dr. Matshidiso Moeti from Botswana is the first woman to head the World Health Organization (WHO)'s Regional Office for Africa. The new regional director has over 36 years of experience in public health. Her goal is to make the organization more responsive, effective and results-oriented. She plans to accelerate progress towards global development goals while tackling emerging threats. The following are edited excerpts of her interview with **Tefo Pheage** for *Africa Renewal*.

Africa Renewal: You held your second annual meeting with Africa's ministers of health recently. Are you happy with its outcome?

Dr. Moeti: Yes, it was a very productive meeting. The ministers adopted key strategies and frameworks covering the broader areas of health security; health systems; women's, children's and adolescent health; ageing; communicable and noncommunicable diseases; financing; and the governance of WHO. They agreed to work towards political commitment and to mobilize more resources for health, as well as strengthen collaboration towards the sustainable development agenda.

Is there any feedback from this meeting that will change your strategy going forward?

I am inspired by the renewed enthusiasm to improve health care in Africa. I am confident that, with all hands on deck, we can improve it.

Please share with us your experience in your first year and what you hope to accomplish during your five-year term.

During the first year, my initial priority was to bring the Ebola virus outbreak in West Africa to an end, which was achieved in December 2015, and to strengthen the region's preparedness and capacity for timely response to outbreaks and emergencies. We also began to restructure WHO in Africa to effectively address the priorities of the continent. During my five-year term, I plan to achieve five priorities: improving health security, strengthening national health systems, sustaining focus on the health-related Sustainable Development Goals (SDGs), addressing the social determinants of health, and transforming the WHO secretariat in Africa into a responsive and results-driven organization.

Dr. Matshidiso Moeti, head of the World Health Organization's Regional Office for Africa. WHO

You were appointed when the Ebola virus was ravaging Guinea, Liberia and Sierra Leone. What helped defeat the virus?

A number of factors were critical in getting to zero cases of Ebola, including high-level engagement with affected countries, donors, technical agencies and communities. I visited the three affected countries to engage with their presidents, national authorities, partners and the community to ensure that all required actions to stop the outbreak were implemented. Secondly, we mobilized financial resources required to support field operations. Thirdly, we deployed more than 3,800 experts from different fields, who played a critical role in implementing all the interventions in the field, such as tracing of contacts, treatment of patients, detection of the virus using mobile laboratories, and sharing of data and information with the global community on the status of the epidemic.

How could these countries be better prepared against future epidemics, like Zika, for instance?

It is critical for countries to enhance their capacity and capabilities to prepare for and respond to any public health event that may threaten public health security by implementing the International Health Regulations. These are a set of rules adopted by all countries to strengthen their core capacities, provide adequate funding and collaborate with partners. They are also designed to enhance cross-border cooperation on preparedness and to respond to threats arising from epidemic- and pandemic-prone diseases. The participation of civil society and the private sector is also very crucial.

What practical steps can African countries take to improve their national health systems?

Countries should strengthen the leadership and governance of health sectors to gain the confidence of all stakeholders. Governments should be more innovative in raising revenues from domestic sources and ensuring that all of their populations have access to essential health services. They should also improve the quality of health services and the safety of patient and health workers, and build partnerships with civil society and other partners in order to expand access. Investing in district and community health systems should be a priority that can contribute towards universal health coverage and the achievement of the SDGs.

SDG 3 calls for the promotion of healthy living and the well-being of all. What role should governments and partners such as WHO play to support Africa in achieving set targets?

The SDGs will require a new integrated and holistic approach from governments. While SDG 3 is the health-focused goal, intersectoral synergy and complementarity are essential for the health sector to meet its goal. Governments require new platforms to coordinate the social sector and health needs, including protecting the most vulnerable in their societies. Our role, as WHO and other partners, is to assist in building the capacity of the health sector so that technicians and decision makers can fulfill these needs.

What role will WHO play in mobilizing resources for poor countries that cannot afford huge budgetary allocations to the health sector?

We play a strong advocacy role in encouraging partners and donor countries to offer financial and other support to the most challenged countries. However, we must acknowledge that there is donor fatigue globally arising from conflicts, migration and humanitarian crises as they demand more resources from the international community. We need to mobilize more resources from within our region so we can gradually reduce reliance on external donations. African countries may also need to look at innovative ways of mobilizing resources through targeted tax regimes (such as has been done elsewhere with airfares and "sin" taxes). WHO will offer technical guidance and expertise to build the capacity to mobilize and use resources more effectively while also ensuring transparency and accountability.

WHO has over the years proposed developing community-based mental health services worldwide. Do you have any update for Africa?

In the African region, there are several countries where community-based mental health services (CBMH) are being developed or strengthened. These usually incorporate a recovery-based approach which emphasises assisting individuals with mental disorders and psychosocial disabilities, vulnerable people and survivors of violence. The majority of community-based services in the region are run by NGOs and religious groups, with family and caregiver support. In some countries, the government co-contributes or takes full responsibility. Countries which have embraced the CBMH approach include Benin, Burkina Faso, DRC, Kenya, Ghana, Namibia, Rwanda, Senegal, South Africa, Togo, Uganda, Zambia and Zimbabwe.

HIV/AIDS and malaria continue to be key health issues in Africa, which has 11% of the world's population but is home to 60% of the people with HIV/AIDS. In the coming years, what would progress look like?

We have made significant progress by reducing deaths due to malaria by 66% in the last 15 years, while deaths due to HIV/AIDS have declined by almost half in the last 10 years. This has been largely due to the greater political commitment, stronger global partnership, increased financing, increased coverage with effective interventions and the meaningful engagement of AIDS patients.

And going forward?

The next five years will be crucial and we have to work hard if we are to achieve the targets of having 90% of people living with HIV knowing their HIV status, 90% of people diagnosed with HIV receiving antiretroviral therapy, and 90% of people who are on treatment achieving viral load suppression.

Of the 20 countries with the highest maternal mortality rates worldwide, 19 are in Africa, which also has the highest neonatal death rate in the world. Where is Africa getting it wrong?

Efforts are underway to tackle the high maternal and neonatal deaths in Africa. Eleven out of those 19 countries with highest maternal deaths were facing humanitarian, conflict or post-conflict situations that may have caused the breakdown of health systems, resulting in a dramatic rise in deaths due to complications that would be easily treatable. But some progress was made.

Can you share with us the areas where progress was made?

By the end of 2015, maternal mortality fell by 45% in the region. WHO specifically supported the development of road maps for reducing maternal and newborn deaths in Africa, and newborn deaths dropped by 38%. WHO supported over 36 countries to build capacity for newborn care both in facilities and the community. And this work continues. I must mention also that HIV-related maternal deaths fell from 10% in 2005 to 2% by the end of 2015.

Many believe a number of Africa's health workers have emigrated to the West. With such a brain drain, how can Africa ensure adequate human resources for the sector?

We continue to encourage countries to expand private-sector training of health workers. We encourage adequate and timely payment of health workers, along with providing incentives to retain health workers in remote areas. Countries should also take into account the WHO Global Code of Practice on the International Recruitment of Health Personnel. The code encourages destination countries to collaborate with source countries in supporting the training of more health care workers. We also urge countries to discourage active recruitment of health personnel from developing countries facing critical shortages. However, the working environment and living conditions ultimately influence performance and motivation of the existing health workers, and we urge governments to address these.

A patient discussing medication with a doctor at HIV/AIDS unit in Botswana. AMO/ Eric Miller

Africa's new strategies to defeat HIV/AIDS

Prevention, treatment and care cut new infections by 14%

BY **JULIETTE MARTIN**

After more than three decades of wrestling the menacing monster, Africa is finally slowing the rate of HIV/AIDS infections to a crawl.

Over the last decade, progress in tackling the pandemic on the continent has been particularly notable, thanks to heightened emphasis on prevention, treatment and care.

According to the latest report by UNAIDS, *Global AIDS Update 2016*, new HIV infections declined by 14% between 2010 and 2015 in Eastern and Southern Africa, the world's most affected region, and by 8% in West and Central Africa.

Despite economic constraints, during this period, sub-Saharan Africa developed the world's biggest HIV treatment programmes, providing antiretroviral (ARV) treatment to more than 12 million people, compared with 11,000 in the year 2000.

By 2015, for instance, about 10 million people living with HIV in East and Southern Africa and 1.8 million in West and Central Africa were on ARVs, according to the report.

To achieve these results, the countries used several health approaches: affordable prices were negotiated for ARV medicines, service delivery systems were simplified and decentralized, and strong supply chains for ARV medicines and other HIV-related commodities were established.

More and more countries are integrating prevention and treatment at the community level, meaning home-based caregivers are now becoming responsible for delivering treatments and managing patients.

In September 2016, South Africa announced it would provide free treatment to all people living with HIV, regardless of the condition of their immune system. Before, only those with a low level of CD4 cells in their blood—indicating an advanced state of infection—were put on free treatment.

Prevention

African countries have also expanded prevention methods, such as voluntary medical male circumcision. Since 2007 more than 10 million men have been circumcised in 14 WHO-designated priority countries: Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

Antenatal care services have helped reduce mother-to-child transmission. More pregnant women are now being tested and those found HIV positive receive medicine to prevent transmission to their unborn babies. This has resulted in a decrease in infections throughout the region.

In Malawi the approach is to provide all pregnant women living with HIV with ARVs for life. This is in addition to other initiatives such as HIV-testing campaigns and linking HIV tests to other health services, which helps to increase HIV screening among the population.

A growing percentage of the programmes in Africa are now funded domestically rather than by external funds. Some countries, such as Zimbabwe, have created an HIV/AIDS tax, while Rwanda has integrated HIV services into its national social insurance scheme, providing free treatment services for those living with HIV.

However, despite Africa's success in combating HIV/AIDS, challenges remain. Sub-Saharan Africa still accounts for two-thirds of the global total of new HIV infections.

In July 2016, UNICEF announced that AIDS is still the number one cause of death for those aged 10–19 in Africa. Despite progress in prevention, the number of young people—especially girls who are more vulnerable to exploitation by older men—contracting HIV needs to be reduced, says UNICEF.

Adolescent girls and young women represent 25% of new HIV infections in sub-Saharan Africa. Women account for 56% of infections among adults due to gender inequalities, insufficient access to education and health services and poverty, among other reasons.

Reducing new infections, according to WHO, will require increased use of condoms, sustainable programmes to encourage changes in sexual behaviour, affordable methods for preventing infection in high-risk populations and expanded treatments for preventing mother-to-child transmissions.

All in all, targeted policies, strong leadership by governments and civil society and engaging people living with HIV will be crucial in sustaining the progress Africa has achieved so far and in meeting global development goals.

Wanted: affordable medicines for all

UN panel calls for new global accords to make drugs cheaper

BY **FRANCK KUWONU**

Pneumonia, an acute infection of the lungs, is the biggest killer of children worldwide even though it is treatable and easily preventable with vaccines.

The disease remains prevalent in some of the poorest regions in South Asia and sub-Saharan Africa in part because of the high price of the vaccines necessary to prevent it. One dose of pneumonia vaccine costs about $68, and it is $204 for the three doses needed to vaccinate one child, although humanitarian organizations may get the vaccines at a lower price.

In 2015 the disease killed nearly 1 million children under the age of 5, accounting for 15% of all worldwide deaths of children of that age group, according to the World Health Organization (WHO).

Health care providers and other groups, such as Médecins sans Frontières (MSF) or Doctors Without Borders, an international medical group that provides assistance to populations in emergency situations, have long complained about what they claim are "artificially high prices" of pneumonia vaccines, among other medicines. They are concerned about not being able to afford these drugs to help prevent the disease in poor countries.

Yet last October, MSF turned down a donation of 1 million free doses of pneumonia vaccine from a New York–based drug company. The group maintained that ad hoc donations are not the solution to the need for affordable medicines and appealed to manufacturers to make drugs more affordable.

In the words of MSF USA director Jason Cone, "free is not always better", and the conditions that come with such donations can delay vaccination campaigns and "undermine long-term efforts to increase access."

In November the drug company finally agreed to lower the price of the vaccine, but only for children in humanitarian emergencies. Still, civil society organizations, including MSF, believe that the price

reduction should be extended to all developing countries.

Report on access

MSF's stance was not widely reported in the media, but coming on the heels of recommendations by a high-level panel of the United Nations Secretary-General on ways to improve access to medicines, it echoed the need to address obstacles in the way of extending to all the benefits of ever-improving health technologies, including drugs, and highlighted the role played by companies in search of huge profits.

Released in September 2016, the *Report of the United Nations Secretary-General's High-Level Panel on Access to Medicines: Promoting Innovation and Access to Health Technologies* calls on governments to negotiate global agreements to reduce the cost of health technologies for rich and poor countries alike. For UN Secretary-General, Ban Ki-moon, the report's message is "simple yet powerful: no one should suffer because they cannot afford medicines, diagnostics, medical devices or vaccines".

The report notes that in a market-driven research and development environment, research into new technologies is incentivised by the prospect of high returns to the developers, while rare diseases affecting comparatively small numbers of people fail to spur innovation.

"With no market incentives, there is an innovation gap in diseases that predominantly affect neglected populations," said Malebona Precious Matsoso, the director-general of the National Department of Health of South Africa, one of the 15 members of the UN panel.

Ruth Dreifuss, former president of the Swiss Confederation, and Festus Mogae, former president of Botswana, co-chaired the high-level panel.

The report calls for new approaches to health research and development to make sure that the benefits of health technology are extended to all.

"Our report calls on governments to negotiate global agreements on the coordination, financing and development of health technologies to complement existing innovation models, including a binding research and development convention that delinks the costs of R & D from end prices," Ms. Matsoso added.

Sky-high prices of medicine and health technologies are of grave concern to developing countries, a situation that gained global attention at the height of the HIV/AIDS epidemic.

Currently the cost of a year's supply of first-line HIV drugs in Africa is less than $100 per person compared to $10,000 in the year 2000, according to UNAIDS.

Back in 2000, only patent-holding drug companies could manufacture antiretroviral (ARV) drugs, but prices started falling when developing countries started producing generic versions and exporting them to other developing countries exempt from the patents.

This was possible thanks to the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), negotiated among members of the World Trade Organisation on public health.

Gradually, though, the flexibility afforded by TRIPS, the report indicated, is being threatened, including through bilateral trade agreements, which is a violation of the integrity and legitimation of the Doha declaration on intellectual property rights and public health.

The report calls on countries to continue making full use of TRIPS and report undue economic and political pressure.

Mental illness: Invisible but devastating

Superstitution often blamed for acute mental health diseases

BY **LANSANA GBERIE**

A patient at the JFK Medical Center and E.S. Grant Mental Health Hospital in Monrovia, Liberia. World Bank/Dominic Chavez

When American film actor Robin Williams, who suffered from depression, committed suicide two years ago, Kenyan humour writer Ted Malanda feigned incredulity. "I can't wrap my mind around the fact that depression is an illness...In fact, it is such a non-issue that African languages never bothered to create a word for it," he wrote in his newspaper, *The Standard*, under the headline "How Depression Has Never Been an African Disease."

Mr. Malanda's scornful quip captures the general African attitude, held as much by officials as by ordinary people, towards an epidemic of mental illness on the continent.

In Mr. Malanda's own country, which is one of the more stable in Africa, health experts have estimated that a fourth of the Kenyan population of 44 million suffers from a range of mental diseases, including schizophrenia and other psychotic disorders, bipolar disorder, depression and severe anxiety.

Kenya has only about 80 psychiatrists and 30 clinical psychologists, fewer than its 500 psychiatric nurses, of which only 250 work in mental health. According to the World Health Organization (WHO), yet the country spends only about 0.05% of its health budget on mental health. About 70% of mental health facilities in the country are located in the capital, Nairobi.

The mental health sector is only marginally better in more prosperous South Africa, which boasts 22 psychiatric hospitals and 36 psychiatric wards in general hospitals. Inequality, however, skews these facilities in favour of only about 14% of the population of 53 million, of which one-third are afflicted with mental diseases, according to experts.

About 75% of mentally ill South Africans have no access to psychiatric or therapeutic care, experts say. The National Health Insurance programme, which could boost access to mental health care, will not be fully implemented until 2025, perhaps later.

Oil-rich Nigeria offers a more dismal picture. Both South Africa and Kenya have more psychiatrists per capita, as well as more psychiatric beds per capita. The WHO estimates that fewer than 10% of mentally ill Nigerians have access to a psychiatrist or health

10%

of mentally ill Nigerians have access to a psychiatrist or health worker.

worker, because there are only 130 psychiatrists in the country of 174 million people. WHO estimates that the number of mentally ill Nigerians ranges from 40 million to 60 million. Disorders like depression, anxiety and schizophrenia are common in Nigeria, as in other countries in Africa.

In 2012, Ghana took a significant step forward in addressing the nation's mental health when it passed Act 846, also known as the Mental Health Act, becoming one of the few countries in Africa to set out a mental illness policy.

Early that year a report by Human Rights Watch (HRW), a non-governmental organization, estimated that 2.8 million Ghanaians (out of a population of 25.9 million) had mental illness.

Ghana has three psychiatric hospitals and about 20 psychiatrists currently. The HRW report cited the then-director of Accra Psychiatric Hospital, Dr. Akwasi Osei, as saying that drug-related psychosis affected 8–10% of all mental patients, while 20–30% of patients were diagnosed with schizophrenia, 20% with bipolar disorder, and 15–20% with major depression. Sadly, 97 out of 100 mental patients who need health care have no access to these services.

Some politically stable countries that have enjoyed economic growth in the past decade also report high incidences of mental health disease, often linked to narcotic use. In Kenya, Nigeria and South Africa triggers of mental illness such as unemployment and violent crime are at critically high levels. The mental health picture is far worse in poorer countries, especially those that have recently experienced civil wars and conflicts, including Liberia and Sierra Leone.

Sierra Leone was a mental health pioneer in Africa. The British established the Kissy Mental Home (now Kissy National Referral Psychiatric Hospital) more than 100 years ago, describing it in an inscription as the "Royal Hospital and Asylum for Africans Rescued from Slavery by British Valour and Philanthropy". A place of confinement for traumatised freed slaves repatriated by British abolitionists, it was sub-Saharan Africa's first, and for many decades only, Western-style mental hospital.

It remains Sierra Leone's only psychiatric hospital. There were a total of 104 patients at the hospital in 2015, of which 75 were men. Most of them were 40 years old or below. Patients live in deplorable conditions, and several of them wear chains.

A 2016 report by Sierra Leone's auditor general states that the hospital does not have a trained psychiatrist except for Dr. Edward Nahim, who is on contract since he retired years ago, and three psychiatric nurses. There is no clinical psychologist, no social worker, no occupational therapist, and no medical officer. The hospital is in a near-derelict state, and parts of it are in total disrepair.

The WHO estimated early this year that 450,000 people in Sierra Leone—which has a population of just over 7 million—suffer from depression every year, and that 75,000 suffer from schizophrenia. There are only 250 hospital beds for psychiatric patients in the country.

September 2015

the UN General Assembly recognized for the first time mental health and substance abuse as global priorities.

Sierra Leone emerged from a brutal civil war 14 years ago. A 2002 report by Dr. Soeren Buus Jensen for the WHO estimated that 400,000 of the country's citizens suffered from mental health disorders like depression and post-traumatic stress disorder—partly the result of their exposure to "severe potentially traumatic events" during the war. Sierra Leone's best treatment institution for mental illness is the privately owned City of Rest, which has 70 rooms, and began as a Christian charity.

The mental health picture in Liberia, which similarly suffered a prolonged civil war, may be worse. Dr. Bernice Dahn, Liberia's minister of health, stated in October 2015 that 400,000 Liberians (out of a population of about 4 million) suffer from various kinds of mental illnesses. About 43% of 1,600 households surveyed in 2008 met the diagnostic criteria for serious depressive illness, major depressive disorder or post-traumatic stress disorder.

Liberia's only psychiatrist, Dr. Benjamin Harris, told the *Voice of America* in 2010 of the growing problem of drug addiction linked to mental illness among young Liberians. He said that 27% of those surveyed out of 1,600 households had had "substance-abuse related problems." He added that substance abuse was a growing problem in Liberia and warned that the situation could get worse.

Liberia has only one psychiatric hospital, E. S. Grant Mental Health Hospital, now part of the government-owned John F. Kennedy Medical Center in Monrovia. It has 80 beds and housed 68 patients (48 males) in October 2015. The country has no rehabilitation centre for drug users.

The widely held view in Africa that mentally ill patients brought the disease upon themselves by using illicit drugs may be one reason African governments do not prioritize mental health.

Experts have also pointed to a tendency in Africa to view acute mental health diseases as supernatural afflictions that can be cured only through spiritual or traditional medicinal interventions. Families of the mentally ill often turn for a cure to these interventions, or to "prayer camps"—retreats where the sick person is often chained to trees and prayed for. This practice is especially prevalent in Nigeria.

The most visible sufferers of mental disease—those often seen roaming the streets of overcrowded cities in Africa—are poor and unemployed, and are therefore designated as vagrants. Vagrancy is a crime in many African countries, which is why many mental health hospitals in Africa serve as prisons—places where poor and vagrant youths are chained, away from respectable society.

In September 2015 the United Nations General Assembly included mental health and substance abuse in the global Sustainable Development Goals, marking the first time world leaders recognized mental health as a global priority. African countries can begin to act on this recognition by increasing their spending on mental health; currently African countries dedicate on average less than 1% of their health budgets (themselves minuscule) to mental health, compared with 6–12% in Europe and North America.

India's medical tourism gets Africans' attention

Many lured by affordable treatment, state-of-the art equipment, top-notch doctors and follow-up care

BY **PAVITHRA RAO**

Surgeons in the operating theatre at a Bangalore hospital, Bangalore, India. Panos/ B. Lawley

Nagged by a sharp back pain three years ago, Abidemi Ogbonna from Lagos, Nigeria, decided to visit a nearby hospital called Apollo. Thinking it was just a minor problem, she was shocked when her physician informed her that she urgently needed a kidney transplant.

The procedure could not be performed locally, her doctor told her. Flying to India was her best chance of a successful operation. Ms. Ogbonna's middle-class family could afford the expenses, and so immediate arrangements were made for her visa.

The Apollo Hospital in Nigeria scheduled a surgery date with its counterpart in India, helped secure Ms. Ogbonna's visa, and booked her flight and accommodation in India. All she needed to do was pay the bill. Once she did, she took the next flight and made the long journey to save her life. She was accompanied by her mother.

Ms. Ogbonna's story is typical of hundreds of Africans who travel outside of their home countries for medical attention.

India is increasingly becoming popular with Africans seeking medical treatment overseas, because of its more affordable, state-of-the-art equipment and its highly skilled doctors. Ms. Ogbonna's other options were the US and the UK; however, health care there is extremely expensive and getting visas to those countries is a nightmare, unlike with India, where visas are issued within a week and treatment is comparatively cheap.

State of health care in Africa

The Global Health Workforce Alliance, which advocates for solutions for countries that lack adequate health care systems, said in its 2015 report that sub-Saharan Africa was facing a severe shortage of health care professionals and lacked adequate health care coverage for those in need of medical treatment.

This is jarring news to a continent that carries a large disease burden, including the world's highest rates of communicable diseases such as malaria, tuberculosis and HIV/AIDS, among others. According to medical journal *BMJ*, "Africa experiences 24% of the global burden of disease, yet it has only 2% of the global supply of doctors and less than 1% of expenditures on global health."

Health care systems in many African countries are inadequately funded. For example, Nigeria, which is one of Africa's richest countries with a national income of $594,257 billion (before the recent currency depreciation), spends only 4.6% on health care.

About 40,000 Nigerians visited India in 2015, half of them for medical reasons, such as transplant surgery, joint replacement and dental surgery, among other procedures, according to the Indian high commissioner to Nigeria, Ajjampur Ghanshyam.

But why are Africans seeking medical care in India?

Why India?

Since the 1990s India has been flaunted as a global leader in "medical tourism," defined as the travel of people to a place other than where they normally reside for the purpose of obtaining medical treatment in that country.

India boasts highly qualified doctors and state-of-the-art equipment, and the treatments are approved by the World Health Organization (WHO) and the US Food and Drug Administration. In addition to quality medical services provided by its hospitals and doctors, patients go to India because medical costs are a lot cheaper compared with the US and UK.

For example, a kidney transplant in India costs about $13,000, while the same procedure will cost up to $300,000 in the US.

"The cost of a kidney transplant surgery with blood-related donor is between $13,000 and $16,000," says Dr. Dheeraj Bojwani, the director of Forerunners Healthcare Consultants, one of the leading medical value providers in India, which is associated with top hospitals and surgeons in the country.

Dr. Bojwani told *Africa Renewal* via e-mail that the $13,000 kidney transplant package includes preoperative medical checkups, consultations and follow-up, surgery and surgeon's fees, anesthetist's fees and drugs.

The package also includes the patient's stay in the hospital (in an air-conditioned deluxe room with TV, cable, and phone); food for the entire duration of the patient's stay in hospital; airport pickup and drop-off; and board for one accompanying attendant.

Many patients from Africa prefer Apollo Hospital, which is headquartered in Chennai in India's state of Tamil Nadu. With more than 60 locations throughout India, it has its own health insurance scheme and has established partnerships with 10 international insurance companies that assist patients to cover medical costs.

On the cost of drugs, India produces generic pharmaceuticals for a fraction of the

price in the West. For example, Cipla, a multinational Indian pharmaceutical company, cut the price of HIV/AIDS antiretroviral drugs to below a dollar a day. This brought the cost of expensive antiretroviral medications down from about $12,000 to no more than $365 per year.

Besides, the Indian government is providing additional incentives to attract foreign patients. These incentives capitalize on the country's "exotic" appeal, and include tourism packages allowing patients to bring along a companion for a discounted travel cost to sightsee landmarks such as the Taj Mahal.

For English-speaking Africans such as Ms. Ogbonna, language is not a barrier, as English is the lingua franca in India. And for those seeking forms of treatment other than surgery, India is home to alternative treatments such as Ayurveda, a plant-based therapy that uses herbs, breathing exercises, diet changes, meditation and stretching for healing.

Follow-up care and sustainability

Ms. Ogbonna has recently returned to her home in Lagos where she is recuperating and where she spoke to *Africa Renewal* by phone. Doctors in India advised her to visit Apollo Hospital in Nigeria for a follow-up. But she fears that because of a lack of equipment, her Lagos doctor may not be able to provide the full post-surgery care that she desires.

Follow-up visits to India may not be possible for kidney transplant patients who have relapsed and who may need to be hospitalized in a matter of minutes, considering the time needed to plan the journey (at least five days to get a visa) and the subsequent flight costs.

To address these issues, the Indian government established the Focus Africa Programme and partnered with the African Union to set up the Pan African e-Network to ensure continuity care for patients.

Established in 2002, the Focus Africa Programme facilitates India's trading with several African countries, including Egypt, Nigeria, Kenya, and South Africa, in affordable pharmaceuticals (in addition to other trade items) so that they become easily accessible on the continent.

The Pan-African e-Network promotes tele-education and tele-medicine to ensure continuity of care for African patients treated in India. Tele-education allows one to receive lessons over an Internet connection or video, while tele-medicine specialises in diagnosing and providing health care from remote locations over a telecommunications device. Such a system allows a patient to access care through teaching hospitals in Africa that are connected to sister hospitals in India.

Indian health care firms are also taking steps to create joint ventures with hospitals in Africa. At the moment they are investing in Egypt, Ethiopia, Kenya, Mauritius and Mozambique.

South Africa

Meanwhile, South Africa has been making medical advances, with statistics showing that in 2012, between 300,000 and 350,000 tourists from all around Africa travelled to South Africa for medical treatment. In addition to shorter travel times than India, South Africa advertises the added allure of safaris and spas.

African travellers coming to South Africa for medical treatments do so less for cost savings and more because of South Africa's advanced infrastructure and medical technology, as well as its doctors, whose skills are on par with international standards.

For Europeans and travellers from the Americas and Asia, South Africa offers an affordable alternative for many cosmetic procedures, thanks to the weak rand. For example, a breast augmentation procedure that costs $8,000 in the UK would cost about $3,600 in South Africa, according to Medical Tourism SA, a consultancy firm that offers total health care information for medical travellers.

American patients who pay about $12,400 for in vitro fertilisation, a procedure that helps a woman become pregnant, can expect to pay a third of that in South Africa.

It is for this reason that the number of African medical tourists going to South Africa by air has increased by 54% in the past three years to 10,477 as of 2015, notes Seye Abimbola in a blog for the African Development Bank.

Going forward

While medical tourism will continue as people shop around for prices and countries vie to improve their offerings, solving the health system challenges in Africa will likely reduce the amount spent on medical tourism. In turn, savings from medical tourism can be used to finance or subsidise health insurance for the poor.

Going forward, Africa should create regional and national medical hubs, as well as tap into pharmaceutical markets in order to produce and distribute generic drugs that will reduce dependence on overseas countries for medical treatment. Though offshore health care comes with many benefits, critics say it is not sustainable and it does not necessarily help African economies.

Taking health services to remote areas

Mobile camel clinics, motorbike ambulances and other innovations for reaching rural folk

BY **KWAMBOKA OYARO**

Health workers attend to patients at a camel mobile clinic in Samburu, Kenya. CHAT

The camel is known for its resilience. Carrying heavy loads in sweltering desert heat over 160 km with little water to drink is no easy job.

This "ship of the desert," however, is built for such terrain—thick footpads help it navigate shifting sand and rocky paths with ease; long legs keep its body away from the surface heat; closing nostrils keep sand at bay; and bushy eyebrows and eyelashes protect the eyes.

These adaptive characteristics and physical features have come in handy for a novel transport system that ferries medical supplies and personnel to remote villages and underserved communities in Kenya.

In neighbouring Uganda, motorcycles are the alternative transport of choice, bringing health care to the remotest areas, while in Malawi, mobile phone technology is being used to combat maternal deaths.

Camel clinics

In Kenya's Samburu County, with harsh climatic conditions and more than 50% of the population living below the poverty line without adequate sanitation, many may die in childbirth or from treatable diseases such as malaria, diarrhoea, tetanus, waterborne diseases and eye and skin infections.

To reach the residents in this remote county, which is more than 300 km north of the capital, Nairobi, camel mobile clinics now traverse the vast area whose terrain is thorny scrubland and semi-arid bush.

Camel mobile clinics have been hailed as one of the more innovative and sustainable means of reaching local communities in far-flung areas. An initiative of Communities Health Africa Trust (CHAT), a non-governmental organization started 16 years ago by Shanni Wreford-Smith, the camel mobile clinics were started six years later and they target these semi-nomadic communities that move from place to place in search of pasture and water.

According to Ms. Wreford-Smith, a mobile clinic comprises 7 to 10 camels, a team of medical workers and camel handlers. In the group are also two family planning and HIV counsellors.

"A normal day for our camel clinics entails waking up early to pack and load the medical supplies on the camels and start the journey before the sun gets too hot. The team walks at the pace of loaded camels and sometimes a distance of 25 km can take a whole day to cover, sometimes we take between two to six hours," Ms. Wreford-Smith told *Africa Renewal*.

Once at their destination, the convoy pitches tent near a big *manyatta* (a traditional homestead established by a family or clan) for two to three days while members of the team do door-to-door mobilizing. The clinic serves on average 30 to 80 people, depending on the size of the *manyatta*, before moving on to the next group. It provides basic health services and holistic family planning, "integrating a strong component of ecological awareness and sensitization."

"We target communities in dire need of health services for common diseases such as malaria and diarrhoea," says Violet Otieno, a social worker and project officer at CHAT. The clinics also do HIV/AIDS testing and counselling, and referrals for antiretroviral treatment.

The camel mobile clinics are donor-funded, which limits the number of trips they make to at least four circuits per

year—with each circuit taking up to two weeks.

The team has learned to safely navigate various risks, including dehydration, attacks from wild animals and being caught between warring clans. It has lost only four camels to sickness since the clinics started 10 years ago.

"The good thing is that the camels enable us to reach places where vehicles cannot [go]," Otieno says, adding that CHAT has now expanded the camel mobile clinics to other counties, including arid and semi-arid Isiolo, Marsabit, Molo and Kitui, to serve these marginalized communities.

In Samburu, like other vast areas in northern Kenya that are inaccessible due to nearly impassable roads, locals are forced to walk for hours to obtain urgent medical care. This has made the camel mobile clinics the most convenient means of providing health services.

In one Samburu village, 34-year-old Jeremiah Samana struggled to contain his tears as he recounted the moment he watched his wife's life ebb away while she was giving birth to their third child. "If it were today [with the camel mobile clinics], she would be alive," he told *Africa Renewal*.

Today, as Samana watches camels loaded with medicines plod past his *manyatta* to deliver services to his neighbours, he is grateful that, although they came a little late to save his wife, he and his children are beneficiaries of the services.

Motorbike ambulances

Health services are hard to come by in Turkana, Kenya's largest county. A shortage of health personnel means that one doctor serves about 50,000 people. The new county government has devised ways of taking health services nearer to the people in this vast, rural county.

"We use motorcycle ambulances to reach our people in the county's seven sub-counties. Since the introduction of this innovation, many people can easily access health services," Jane Ajele, the county's health minister, told *Africa Renewal*.

The ministry has six motorcycle ambulances serving the sub-counties. Demand for the services is high, and Ajele says there are plans to increase the number before the end of this year.

"The good thing about these 'ambulances' is that they can navigate impassable roads to save lives. Besides carrying medicine, they also ferry women in labour to the nearest health facility," she said.

Similarly, Tana River County has introduced four motorcycle ambulances for piloting in four remote villages which have one of the highest numbers of maternal deaths in the country. The villages are Biressa, Dende, Wayu-Boro, and Tawakal.

Uganda's village ambulances

As of last June, Uganda was using motorcycle ambulances to reach people in the rural western region.

Commonly known as "village ambulances," these three-wheeled motorcycles take medicines, medical supplies and information to patients in remote villages. Before their introduction, community health workers would use improvised stretchers, or carry the sick on their backs to the nearest health facility. Many never made it, as the journey was long and arduous.

"With the village ambulances," Swizen Kisembe, a health worker, told the South African Broadcasting Corporation in September, "many lives are being saved."

Village ambulances have also turned out to be cheaper and safer than conventional ambulances.

Malawi: Health e-Innovation

Malawi's "health centres by phone" have discovered a novel way of providing crucial health care services to people in rural areas through the use of text messages.

A basic phone becomes a clinic through which a patient gets all the information he or she requires from a doctor without going to a clinic. The text message service also gives tips and reminders about taking medications, making it easy and convenient to connect patients and health providers any time of the day.

This has proven helpful in providing pregnant women with necessary prenatal and also postnatal information. Some of the messages encourage the use of mosquito nets to prevent malaria, others give tips for preventing mother-to-child HIV transmission and for improved health care in general.

The toll-free line, supported by Airtel, a mobile phone company, serves more than 500,000 mothers and children. The Malawi government, which aims to reduce maternal mortality, has endorsed the mobile phone innovation.

A camel mobile clinic team on the move. CHAT

Dying from lack of medicines

Encouraging local production, right policies the way out

BY **TEFO PHEAGE**

Approximately 1.6 million Africans died of malaria, tuberculosis and HIV-related illnesses in 2015. These diseases can be prevented or treated with timely access to appropriate and affordable medicines, vaccines and other health services. But less than 2% of drugs consumed in Africa are produced on the continent, meaning that many sick patients do not have access to locally produced drugs and may not afford to buy the imported ones.

Without access to medicines, Africans are susceptible to the three big killer diseases on the continent: malaria, tuberculosis and HIV/AIDS. Globally, 50% of children under five who die of pneumonia, diarrhoea, measles, HIV, tuberculosis and malaria are in Africa, according to the World Health Organisation (WHO). The organisation defines having access to medicine as having medicines continuously available and affordable at health facilities that are within one hour's walk of the population.

In some parts of Zimbabwe, for example, some nurses give painkillers to sick patients as a "treat-all drug," says Charles Ndlovu, a Zimbabwean living in Botswana. Some of his family members have been treated in hospitals in Zimbabwe. With most medicines unavailable, the nurses have little choice.

Dave Puo, from Mpumalanga in South Africa, says that in his country, "when you seek medical attention, you are often informed that there is no medication and advised to go to the big hospitals," which the majority of the poor cannot afford. "The system does not care about your [empty] pockets."

Inhibiting factors

About 80% of Africans, mostly those in the middle-income bracket and below, rely on public health facilities, reported the World Bank in 2013. With public health facilities suffering chronic shortages of critical drugs, many patients die of easily curable diseases.

Several factors inhibit access to medicines, but the major ones, according to the WHO, are the shortage of resources and the lack of skilled personnel.

"Low-income countries experience poor availability of essential medicines in health facilities, substandard-quality treatments, frequent stock-outs and suboptimal prescription and use of medicines," says the world health body.

Africa's inefficient and bureaucratic public sector supply system is often plagued by poor procurement practices that make drugs very costly or unavailable. Added to these are the poor transportation system, a lack of storage facilities for pharmaceutical products and a weak manufacturing capacity.

Africa's capacity for pharmaceutical research and development (R & D) and local drug production still has a long way to go, say experts. Only 37 out of 54 African states have some level of pharmaceutical production. Except South Africa, which boasts some active local pharmaceutical ingredients, most countries rely on imported ingredients.

The result is that Africa imports 70% of its pharmaceutical products, with India alone accounting for nearly 18% of imports in 2011. Pharmaceutical imports in Africa include up to 80% of the antiretroviral drugs (ARVs) used to treat HIV/AIDS, according to trade data.

"Many African governments spend a disproportionate amount of their scarce resources on procuring medicines," writes Carlos Lopes, former executive secretary of the United Nations Economic Commission for Africa.

To produce medicines, a country must abide by Current Good Manufacturing Practices (CGMP), which are enforced by the United States and other governments to ensure the quality of manufacturing processes and facilities. Many African countries do not have the technical, financial or human resources required for high-scale drug production.

But Egypt, Morocco, South Africa and Tunisia have made progress in local pharmaceutical productions. Morocco is Africa's second-largest pharmaceutical producer (after South Africa), and has 40 pharmaceutical manufacturing companies that supply 70% of products for local consumption and also exports to neighbouring countries. Countries such as Ghana, Kenya, Nigeria and Tanzania are currently developing production capacity.

Suspicions

Many African political leaders and development experts believe that the world's

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biggest pharmaceutical companies are reluctant to offer technical support to African manufacturers. For example, in 2001, 39 international pharmaceutical companies dragged the South African government to court to challenge its plans to manufacture and import cheap, generic HIV/AIDS drugs.

The companies claimed that South Africa's plans breached their patent rights. Although they later withdrew the matter from court following pressure from groups that advocate for international access to medicines, South Africa's late president Nelson Mandela accused the companies of exploiting the developing world by charging exorbitant fees for HIV/AIDS drugs. "That is completely wrong and must be condemned," he said at the time.

There is evidence, however, that local production improves access and brings down the cost of medicines. "Ever since the high-tech generic drug production [facility], Cinpharm-Cameroon, was set up, it is relatively easier for Camerooni-ans to have access to medicines," says Mr. Lopes. "Now a low-wage earner can access a course of antibiotics at a lower price than a Kenyan counterpart." Worth $24 million, Cinpharm-Cameroon produces 40 different drugs.

The Trade Related Aspects of Intellectual Property Rights (TRIPS) regulation of the World Trade Organization (WTO), in force since 1986, curtails the right of companies to manufacture generic drugs, forcing countries to rely on brand-name products. However, the WTO in 2006 granted developing countries a 10-year waiver to manufacture generic drugs using the intellectual property rights of big pharmaceutical companies overseas.

Despite US objections, the waiver, which expired this year, was extended until two-thirds of WTO members decide to remove it. Experts believe that is unlikely to happen, as the US appears to be the only big country insisting on its removal.

WHO director-general Dr. Margaret Chan remarked in 2010 that the debate on access to medicine is often clouded by suspicions: "Suspicions that the rules governing international trade in pharmaceutical products are rigged to favour the rich and powerful; that economic interests will trump health concerns."

The debate, Dr. Chan added, is complicated by deep mistrust. "Countries unskilled in trade negotiations fear they will be tricked or duped. Countries fear that pharmaceutical companies will use unfair tactics, really, every trick in the book, to reduce competition from lower-priced generics."

Dr. Chan added that, while the ethical argument of not depriving people of access to life-saving medicines is a reasonable one, the for-profit pharmaceutical companies respond to market forces. "What incentives does this industry have to fix prices according to their affordability among the poor?"

Progress in some countries

Availability of medicines is one thing, but affordability is another important factor. Countries such as Ghana and South Africa have made efforts to make drugs affordable through insurance schemes, but these efforts have been largely feeble. Overall, insurance schemes cover less than 8% of the population of sub-Saharan Africa and do not cover prescription medicines on an outpatient basis.

To underscore the problem of affordability, WHO notes that treating a child for malaria in Uganda with artemisinin combination therapy will cost a household the equivalent of 11 days' income. In Kenya, a seven-day treatment course of ciprofloxacin antibiotic could cost a month's wages.

Despite obvious difficulties, some countries are making strides in improving access to medicine. Botswana is among the countries that could be malaria-free by the year 2020, reports WHO. Director-general of Botswana's health ministry Shenaaz el Halabi told Africa Renewal, "We have seen a tremendous improvement in our health care system in recent years."

Ethiopia has made considerable progress too, particularly in the control of HIV and treatment of malaria, tuberculosis and other diseases. "Ethiopia's increased investments in expanding effective health coverage—it rose to 95% in 2013 to 2014—has already improved health indicators in the population, reducing child mortality and HIV/AIDS, malaria and tuberculosis," states WHO.

Recourse to traditional medicines

Faced with difficulties in accessing modern medicines, many Africans resort to ritual and herbal remedies, known across diverse African societies as traditional medicine.

But Ali Arazeem Abdullahi, a sociology professor at the University of Ilorin, Nigeria, cautions that "it is a general belief in medical circles [in Africa] that traditional medicine defies scientific procedures in terms of objectivity, measurement, codification and classification."

Acknowledging there are quacks that should be checkmated, Professor Abdullahi called for political will to rebrand and standardize traditional medicine practices.

Experts believe that Africa's solutions to improving citizen access to medicine could lie in stimulating local production, developing the right policies and infrastructure, and training and retaining its medical talents.

Nurses attending to patients at a hospital in Monrovia, Liberia. Panos/Robin Hammond

Migrants from Africa and elsewhere rescued from a smuggler's boat by an Italian naval ship in the Mediterranean. © UNHCR/A. D'Amato

REFUGEES AND MIGRANTS

Young Ghanaians risk all for "better" life

Some migrate within Africa while others take the risky route to Europe

BY **EFAM AWO DOVI**

Every week, in the Brong Ahafo Region – one of Ghana's major food baskets – vehicles load up with men between 18 and 40 years old. Many, mostly the younger men, hope to reach Europe, while others head for more prosperous countries in Africa. Irrespective of their final destination, they have common aspirations: hopes of good jobs and better lives for themselves and the families they leave behind.

Kofi Twum made that trip years ago. He was only 18 and had lost his father at an early age. His mother, a subsistence farmer, became the sole breadwinner of the family. When Twum completed junior secondary school, he hawked yams to help his mother. But their living conditions worsened and Twum, fifth among six children, felt the need to work elsewhere.

"I wanted to go to Italy to be able to support my mother," Twum told *Africa Renewal* from his home in the town of Nkoranza in northern Ghana.

In 2014, with financial support from his brother, Twum joined a group of 35 young men on a journey through the Sahara Desert to Libya, where they were to take a boat to Europe.

However, hopping a crowded boat out of Libya on his third attempt to cross the Mediterranean, he was arrested and deported to Ghana. He arrived empty-handed. Twum, now a street preacher in his 30s, tells *Africa Renewal* that he still hopes to make it to Europe one day, this time by some other route.

A hazardous journey

Most Ghanaian migrants trying to reach Europe via Libya go through Burkina Faso to Agadez, Niger. From there they join others from West Africa and other areas who are fleeing conflict and persecution.

With the services of middlemen, they travel on overloaded trucks in convoys and part of the way on foot through the Sahara Desert to the Borkou region near the Libyan border. It's a death-defying experience. Many die from exhaustion and dehydration.

Twum recalls the human traffickers and their extortionate demands for money. Also unforgettable was the sight of many lifeless bodies abandoned in the hot Saharan Desert. "Some were leaning on the rocks, they looked like they were sleeping, others were buried in the dust," he recalled.

Three of his fellow travellers died. "They couldn't continue the walk. When that happens, we try to encourage them, but after a while you have to leave them, because if you're left behind you'll lose your way, and you'll soon die," he said. "These were people I knew, we travelled together from Nkoronza. I called their families later from Tripoli to inform them."

Twum's story is all too common in the Brong Ahafo Region, with echoes across Ghana and other sub-Saharan African countries.

During the 2011 Libyan crisis and the overthrow of Muammar Gaddafi, more than 18,000 Ghanaian migrants in Libya were

evacuated, according to the International Organization for Migration (IOM) office in Ghana. The actual number of returnees, however, could be higher as some migrants managed to get out of Libya on their own before the crisis worsened.

The majority of the returnees were sent back to the Brong Ahafo Region, from which they came, according to the IOM, which supported the Ghanaian government in evacuating its stranded nationals.

For many families in Brong Ahafo, having a relative in Europe confers prestige and the prospect of remittances. "Every household hopes to have someone in Europe," says Walter Kwao-Anati, the director of migration at Ghana's Ministry of the Interior.

In some cases, he adds, "There is community support for relatives to leave, because your family will be looked down upon if no one has left for Europe."

And there is also the expectation of financial support to the family back home, which helps to improve the family's living conditions. According to the African Development Bank's African Economic Outlook 2015 report, remittances, at $64 billion in 2015, remain the most stable and important single source of external finance to Africa.

But beneath the veil of perceived prestige are bigger national development issues. Kwao-Anati admits that in the case of Ghana, "Poverty is one of the major reasons why people migrate in search of economic opportunities."

Oil fails to save the day

Migration is not a new phenomenon in Africa. Around the 1970s and 1980s, most Ghanaian migrants moved to neighbouring countries like Nigeria and Côte d'Ivoire. In recent years, however, irregular migration—traveling without documentation and through unapproved routes—from sub-Saharan Africa towards Europe has substantially increased.

Walker Kwao-Anati says, "As the economic situation on the continent becomes difficult, many young migrants started taking the deadly journey to Europe."

Ghana, the world's second-largest cocoa producer (behind Côte d'Ivoire), is also endowed with many natural resources—precious metals like gold and silver as well as diamonds, bauxite, cocoa, timber and crude oil.

When the country started crude oil production in commercial quantities in 2011, many were hopeful of better lives. That year the country's economy grew at a record high of 15%, the fastest rate in the world, according to the IMF.

At the end of 2012, declining productivity at one of the country's largest oil projects, the Jubilee oil field, led to a decline in revenues for the government, which had budgeted for oil revenue of more than $650 million. The corresponding shortfall was more than $410 million.

Soon after, the country faced a huge public-sector wage bill—following the implementation of a new salary scheme—and ballooning debt, leading to the twin problems of a huge budget deficit and double-digit inflation. The situation was worsened by the collapse of oil prices, which cut a hole in expected revenue.

Dashed hopes

By 2015 a surge in migration from Ghana made the country the eleventh most common nationality among migrants who arrived in Europe by boat, according to the IOM. Arrivals in Italy alone the same year totaled 4,431. As of July of this year, 2,700 such arrivals have been recorded.

Ghana, once touted as an African success story, has now turned to the IMF for support. Today the country's ballooning debt, coupled with high interest payments, remains a source of concern.

Ghana's vast resources have not translated into better lives for a majority of the people. Kofi Obeng has been among that majority. He comes from the Eastern Region—an area endowed with diamonds, gold and other mineral resources that Ghana exports.

As a young man, Obeng says, he did all kinds of jobs, even going through mine dumps on illegal mining sites hoping to find missed ore.

But by age 12, he dropped out of school when his grandmother could no longer afford his school fees. Soon he and his friends were heading for Bolgatanga in northern Ghana, where they joined 45 others aiming to reach Europe. He made it only to Libya. But during his three years' stay in that country, Obeng says he managed to send an average of $500 to his family every other month. He returned home during the Libyan crisis.

Today, at 33 years old, Obeng is a shop assistant in a mall in the Ghanaian capital, Accra, earning 400 cedis ($100) a month. With younger brothers and sisters to support, he says, he does not make enough to go around. He is looking for another opportunity to leave Ghana. For people like him, he says, the only hope of making it in life is to go outside the country.

Linking education to job market

In a joint interview with *Africa Renewal*, Kazumi Nakamura and Kojo Wilmot of the IOM office in Ghana blamed the surge in youth migration on an inadequate educational system, among other factors.

"There is a mismatch between the educational system and the job market, leaving a huge skills gap," notes Nakamura, who manages the Ghana Integrated Migration Management Approach (GIMMA) project, a three-year initiative intended to contribute to the government's efforts to develop a holistic approach to effective management of migration.

Wilmot says that while conflicts and changes in the weather pattern in northern Ghana are influencing internal migration, unemployment among the youth is largely responsible for external migration. "Many are coming out of school with no jobs," he says.

According to the United Nations, youth unemployment is a major driver of voluntary migration, as well as a threat to peace and security in the region. Without decent jobs and meaningful employment, African youths remain highly vulnerable to exploitation.

Need for policies

In April of this year, Ghana launched its first National Migration Policy, which provides a comprehensive framework for managing all aspects of the country's internal, intra-regional and international migration flows. The director of migration, Kwao-Anati, says new policies will enable the government to engage communities more effectively and to gather data to deal with the country's growing migration challenges.

The IOM's Nakamura says, "There is a lot more to be done," and stresses the need for governments to do more to link development programmes to employment and job creation.

Africa most affected by refugee crisis

Ethiopia and Uganda praised for open-door policy

BY **SULAIMAN MOMODU**

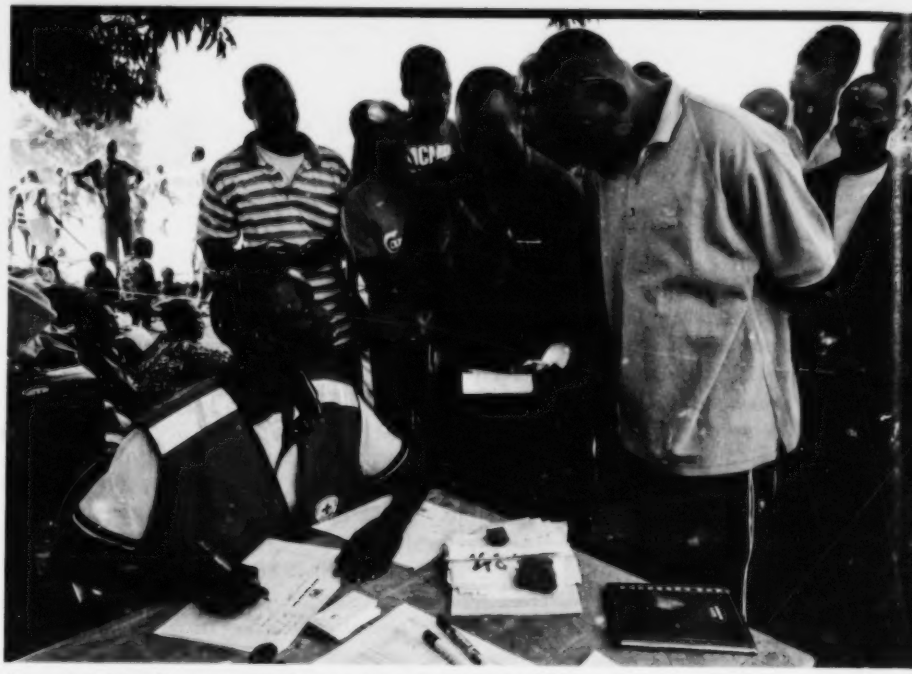
As Germany, France and other European countries contend with an unprecedented influx of refugees from Syria, Iraq, Afghanistan and elsewhere, shocking tales of women and children drowning in the Mediterranean Sea are repeated over and over by media networks worldwide.

But the distress over refugees landing in Europe has overshadowed the efforts of African countries also grappling with refugee emergencies. While European nations seek to limit the "economic" refugees as opposed to asylum seekers, Ethiopia, for example, is taking in thousands of refugees from neighbouring countries.

According to the United Nations, developing countries, mostly in Africa, are taking in a disproportionate number of refugees – currently 80% of the world's refugee population. Refugees hosted in developing countries put enormous pressure on water and health care systems in host communities.

The Office of the United Nations High Commissioner for Refugees (UNHCR) says the world is currently facing the highest levels of displacement ever in history, with an unprecedented 65.3 million people forced from their homes by war, internal conflicts, drought or poor economies. Among these are 21.3 million refugees, over half of whom are under the age of 18; the rest are economic migrants and internally displaced persons.

People are forcibly displaced at a rate of 34,000 per day due to conflict or persecution. Currently there are also 10 million stateless people worldwide who have been denied a nationality and access to basic rights such as education, health care, employment and freedom of movement.



A man and his family register as refugees in Uganda. UNHCR/F. Noy

Ethiopia's open-door policy

Ethiopia hosts nearly 740,000 refugees, mostly from Somalia, Eritrea, Sudan and South Sudan, the largest refugee population in a single African country. The country maintains an open-door policy that welcomes refugees and allows humanitarian access and protection.

In the Central African Republic, clashes among rival groups have forced thousands to flee their homes. In Nigeria, more than 2 million people have been forcibly displaced, including the 1.87 million who have fled from the militant group Boko Haram's violence since 2014. Some 195,350 people have sought refuge in neighbouring Cameroon, Chad and Niger.

"Refugees have skills, ideas, hopes and dreams.... They are also tough, resilient and creative, with the energy and drive to shape their own destinies, given the chance," says UN High Commissioner for Refugees Filippo Grandi.

At Kule refugee camp in Ethiopia's Gambella region, Nyahok Reath, a 13-year-old refugee from South Sudan, told *Africa Renewal* that after her country gained independence in 2011, life in the world's newest nation was good until December 2013, when conflict was reignited. She then trekked for a week to Ethiopia with her family and little food.

"In South Sudan, we had enough to eat, school was good, and we had a lot of cows. But when war started, we had to leave everything and flee," she said sadly. "As refugees, we do gardening here to get some money, but sometimes I have problems with food and even go to school barefoot." The Ethiopian government, UNHCR and its partners assist South Sudanese refugees.

The young girl wants to become a pilot after watching UN aid planes take off from the airport near her home in South Sudan.

"I would like to go to different parts of the world and help people in need," said Nyahok, who is in the seventh grade in a primary school in the camp. The school lacks

10th, 11th, and 12th grades, making Nyahok's chances of graduating slim. Renewed fighting since July has brought the total number of South Sudanese refugees in East Africa to more than 1 million.

With a worsening refugee situation, UNHCR Assistant High Commissioner for Protection Volker Türk called in October for a global redoubling of efforts to provide refugee protection.

"The monsters in today's world most certainly are the horrors of raging conflict, violence and human rights abuses, which people flee within or outside their countries year after year," Mr. Türk told the UN agency's annual executive committee of 98 countries, which met in October in Geneva.

Uganda's best policy

Mr. Türk commended countries that continue to keep their borders open, providing refugees with opportunities to start anew. He cited Uganda's "generous refugee law and policy regime" in response to the influx of South Sudanese refugees as an example to emulate. Uganda grants refugees free movement, employment opportunities and land for building new homes or farming.

The World Bank, the Refugees Studies Centre (an arm of the UK's Oxford University that researches the causes and consequences of forced migration) and other organizations have praised Uganda's refugee policy. More than 500,000 refugees from neighbouring countries, including Burundi, Democratic Republic of Congo and South Sudan, have settled in Uganda.

Humanitarian activists agree that today's challenges are interconnected and complex, with population growth, climate change, urbanization, water scarcity and food and energy insecurity exacerbating conflicts.

UN Refugee Commissioner Grandi observed during the UNHCR's annual executive committee meeting in Geneva in October that "people are moving more rapidly, over longer distances and for a more complex range of reasons than at any time in history."

"Refugees have been deprived of their homes," said UN Secretary-General Ban Ki-moon, "but they must not be deprived of their futures." They face basic survival difficulties. On arriving in a new country, they usually need immediate shelter, food, water, medical care and security.

Last September the UN General Assembly in New York held its first-ever high-level summit to address the humanitarian needs of large numbers of refugees and migrants. Member states adopted an agreement in which they committed to providing better educational opportunities for refugee children, improving working conditions for displaced adults and fighting xenophobia.

Mr. Ban called the Declaration for Refugees and Migrants "a breakthrough in our collective efforts to address the challenges of human mobility."

With the declaration, member states also pledged to "expand the number and range of legal pathways available for refugees to be admitted to, or resettled in, third countries," so refugees can move more freely instead of being stuck in the first country they enter. A pledge to resettle 10% of the world's refugees within the developed world, which had been canvassed, was excluded from the declaration.

At the same time, at the UN headquarters in New York, the leaders of Canada, Ethiopia, Germany, Jordan, Mexico and Sweden joined US President Barack Obama to host the Leaders' Summit on Refugees. As a precondition for speaking at the summit, leaders of countries made new pledges, such as to give more support, make new admissions or give assistance to refugee host countries.

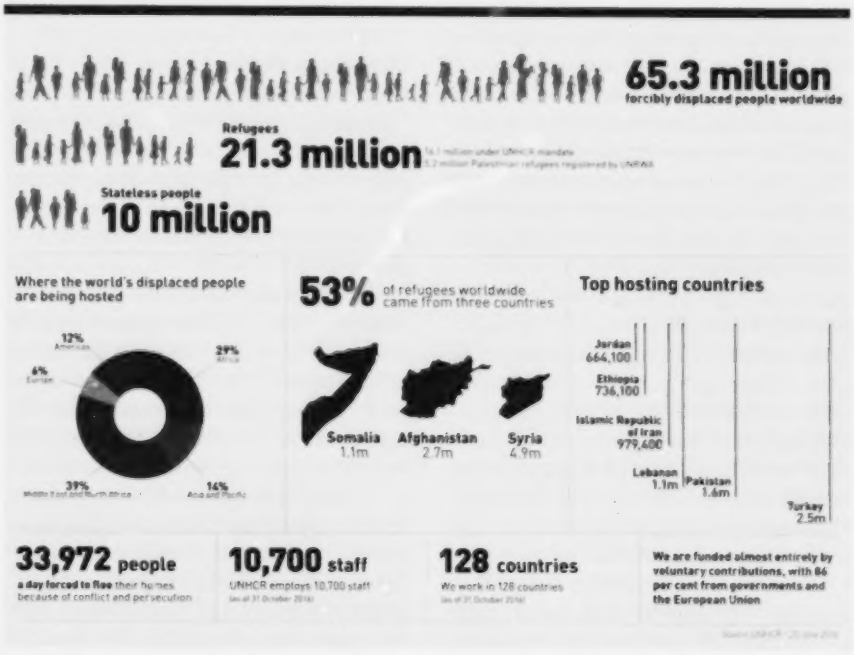
President Obama described the refugee crisis as "a test of our common humanity," adding, "We must recognize that refugees are a symptom of larger failures—be it war, ethnic tensions, or persecution."

While the leaders' summit focused on refugees, not migrants, the UN General Assembly High-Level Meeting on Refugees and Migrants addressed large movements of both; the two events were complementary. Critics, however, say that the UN summits spent little time addressing the root causes of forced displacement and insecurities that force people to flee.

Many hope that incoming UN Secretary-General António Guterres, a former head of UNHCR, will be able to highlight the plight of refugees and consequently elicit more proactive interventions.

"During his 10 years at UNHCR, Mr. Guterres managed some of the biggest refugee crises of our times," says Mr. Grandi, adding, "António Guterres was a tireless advocate for refugees, the internally displaced and the stateless, defending their rights in the field and at the highest political levels."

Despite substantial increases in the UNHCR annual budget to meet the crises of the last five years, Mr. Grandi says funds available for 2016 so far stand at US$3.76 billion – just half of total funding requirements.



Commodity prices crash hits Africa

Volatile global financial markets and weaknesses in global growth to blame

BY **KINGSLEY IGHOBOR**

Just three years ago, most of the world's fastest-growing economies were in Africa, among them Angola, Chad, Ethiopia, Mozambique, Nigeria, Rwanda and Sierra Leone. A middle class was emerging, led by young, tech-savvy entrepreneurs who bought flashy cars, new houses and the latest smartphones.

Africa's impressive average economic growth of around 5%, over the 14 years to 2014, saw economists toasting to the continent's development potential. Buoyed primarily by high commodity prices and marginal exposure to global financial markets, the African economy as a whole was largely undisturbed by the 2009 global financial crisis. And steady flows of foreign direct investment assured a sustainable growth trajectory.

During that period, China, India, Brazil and European countries scrambled for a slice of Africa's investment opportunities. The Brookings Institution, a Washington D.C.–based think tank, stated in 2013 that it was a mistake not to "take into account the current realities of the emerging continent" and "leverage the potential that Africa presents as a market for American goods." Even *The Economist*, a usually restrained UK publication, splashed an "Africa Rising" title on its 11 December 2011 cover, which depicted a silhouette of a child flying a kite of an African map.

Fortune reversal

A precipitous crash in commodity prices is changing that upbeat African narrative. Already, Angola, Liberia, Mozambique, Nigeria, Sierra Leone, and Uganda — the African countries that depend most heavily on commodities—such as oil, gold, diamonds, bauxite, rutile, timber and copper—are in dire straits.

Economists also attribute this sudden reversal of fortune to other factors such as volatile global financial markets, weaknesses in global growth, particularly in China, Brazil and India, rising borrowing costs and severe infrastructure constraints (particularly of electricity supply) in many countries. But it is the plunge in commodity prices that has dealt the most devastating blow.

The price of oil plummeted from $100 a barrel in 2013 to $26 a barrel in February 2016, hovering around $50 a barrel in October. Without sufficient oil earnings, Africa's oil producers, particularly Nigeria, Angola, Equatorial Guinea, Libya, Algeria and Egypt, face serious economic head winds.

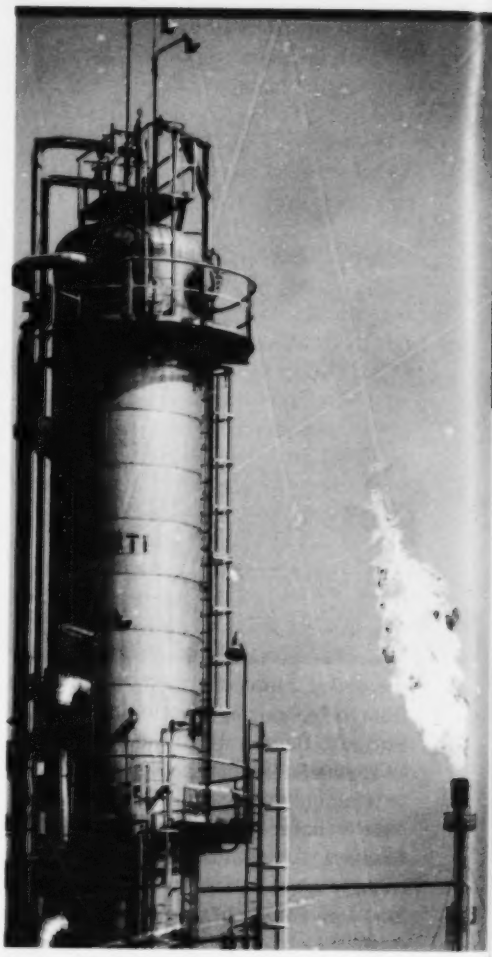
For Nigeria and Angola, Africa's largest producers, oil proceeds account for more than 90% of exports and over 70% of the national budget. With low per-barrel prices, economic growth in all of Africa's oil-exporting countries fell from an average of 5.4% in 2014 to an average of 2.9% in 2016. Consider that Angola generated $60.2 billion from oil in 2014 and $33.4 billion in 2015, a significant drop in revenue that mirrors the situation in other countries.

Significant shock

Copper-producing countries have not fared any better as prices dropped to their lowest level since 1998. The World Bank reports that in February 2016, "copper prices declined by almost a third from their peak in February 2011 to $4,595 per tonne."

Tsidi Tsikata, who led an International Monetary Fund (IMF) assessment mission to Zambia in March this year, has issued a bleak report: "The Zambian economy is under intense pressure," he warns, calling for action to regain macroeconomic stability.

More than half of Zambia's copper producers are losing money, and big players in the country such as Glencore, an Anglo-Swiss multinational and Luanshya Copper Mines, a Chinese firm, have shut shops, with thousands losing their jobs. The Zambian economy is currently growing at 3%, down from 7% in 2014. Although some analysts see a rebound in the Chinese economy, in recent years China, which buys up to 40% of copper worldwide, has not been able to afford huge purchases due to economic slowdown.



An oil production facility in Nigeria. Panos/I

Sierra Leone is grappling with falling prices of iron ore, even as it recovers from the Ebola epidemic. African Minerals, a London-registered mines company, used to manage the iron ore mines in Tonkolili,

northern Sierra Leone, which are worth over $1 billion. Tonkolili has the biggest iron ore deposit in Africa and the third largest in the world.

In 2011 iron ore sold for $191 per tonne, but it fell to $45 per tonne in June 2016. Faced with corruption allegations and huge financial losses, Africa Minerals sold the mines in December 2015 to China's state-owned Shandong Iron and Steel Group. Mining is expected to resume by the end of 2016.

Iron ore is Sierra Leone's economic lifeline. "The iron ore price decline affected macro-financial stability and reversed the country's remarkable positive growth trajectory," maintains the African Development Bank.

"The fall in commodity prices represents a significant shock for the sub-Saharan African region, as fuels, ore and metals account for more than 60% of the region's exports," notes the World Bank.

Ordinary citizens feel the impact in currency depreciation and rising inflation. The value of Nigeria's naira fell from 150 to 450 naira to the dollar between January 2014 and October 2016. The Sierra Leonean currency faced the same fate, declining to 6,500 leones to the dollar, from 5,000 leones a year ago.

Nigeria's currency depreciation means it has lost the right to call itself Africa's largest economy. After rebasing (a process of adopting new prices to measure a country's GDP output) in 2014, the Nigerian economy was reported to be worth $488 billion. With the naira's depreciation due to a decline in export earnings, the economy has shrunk to $296 billion, according to data released in August by the IMF.

Skyrocketing prices of goods and services without a commensurate increase in earnings could affect prices of food and stoke social unrest across Africa, experts fear.

Austerity measures

Commodity-dependent countries are faced with huge budget deficits, which is why Angola, Ghana and Zambia have received or are intensely negotiating for IMF bailout loans.

Nigeria is overhauling its tax system to increase revenues, aggressively fighting corruption and recovering stolen money stashed in foreign banks, and at the same time intends to borrow money from China and local banks. The country wants to sell off some of its national assets, including energy and oil corporations.

Africa's most populous nation will "seek a dramatic shift from spending on recurrent expenditures to spending on capital aspects of the budget," said Udoma Udo Udoma, minister of budget and national planning. It officially declared a recession in August after two quarters of negative growth.

Last March, Sierra Leone announced a 30% cut in recurrent government expenditures, suspended financing for capital projects and the purchase of official furniture, eliminated travel allowances for government officials and began implementing a 50% cut in vehicle maintenance allowance, among other measures.

However, Herbert M'cleod, a leading Sierra Leonean economist, says, "It is bad policies and bad management that have brought us here," and recommends using proceeds from mining to boost jobs creation and power supply and to construct roads, among other things.

The Ugandan government has scrapped gasoline and diesel subsidies, suspended construction of new roads, banned non-essential foreign travels and stopped the launch of a new airline. Zambia is cutting subsidies on electricity and agricultural inputs.

South Africa, whose largest exports are iron ore, coal, gold and other minerals, is also affected by the fall in commodity prices. While presenting the 2016 budget, finance minister Pravin Gordham said, "There is no doubt that we are in crisis," before announcing an unprecedented spending cut of 25 billion rand (about $1.7 billion). Liberia, Gambia and other countries are also implementing various austerity measures.

The 2015 study, *The Effect of Commodity Prices on African Economic Growth* by Hangnile Nathalie Olga Tiawara of St. Cloud State University, United States, found that commodity price changes are linked to the pace of economic growth in commodity-dependent countries. In short, when prices fall, these economies falter.

Good news for some countries

The Economic Commission for Africa (ECA) has over the years been encouraging countries to industrialize by diversifying away from commodities and, at the least, to add value to their commodities. Former ECA executive secretary Carlos Lopes repeatedly spoke about the paradox of countries' importing Toblerone chocolates from Switzerland when the continent produces 70% of the world's cocoa, from which chocolates are made.

As oil-exporting countries deal with economic anxieties, low oil prices are good news for oil importers like Kenya, Rwanda and Tanzania. It means these countries spend less and can redirect excess funds into critically needed infrastructure such as roads, bridges and energy. Robust growth in these economies will continue, forecasts the World Bank.

The fall in commodity prices represents a significant shock for the sub-Saharan African region, as fuels, ore and metals account for more than 60% of the region's exports.

Going forward, mitigating efforts will require good financial management and increases in revenue generation locally, experts say. "As countries adjust to a more challenging global environment, stronger efforts to increase domestic resource mobilization will be needed," says Makhtar Diop, World Bank vice-president for Africa.

There may yet be a silver lining: experts expect the impact of current belt-tightening policies in Africa to kick in in the medium to long term, providing a cushion for national budgets.

Also, countries will learn the lessons of commodity price movements and will be more inclined to continue diversifying their economies. The World Bank says that agriculture and urbanization are important sectors for investments.

Finally, when earnings are in an upswing, countries must save for the rainy day, experts recommend.

Africa welcomes new trade initiatives from Japanese investors

TICAD VI's Nairobi Declaration is aimed at boosting economic ties

BY **KINGSLEY IGHOBOR**

African leaders who took part in the Sixth Tokyo International Conference on Africa's Development (TICAD VI), held last August in Nairobi, Kenya, are eager to test the latest Japanese commitment to investment and development on the continent and how it will improve the quality of life of African citizens.

After the welcoming ceremony, which was full of colour and culture, the leaders, together with business and civil society representatives, quickly began the serious business of fashioning ways to transform Africa's economies and improve political stability.

Japanese Prime Minister Shinzo Abe, who co-chaired TICAD VI with Kenya's President Uhuru Kenyatta, had come with leaders of more than 70 Japanese companies to the event in Nairobi. Also attending were presidents Jacob Zuma of South Africa, Muhammadu Buhari of Nigeria, Macky Sall of Senegal, Ellen Johnson-Sirleaf of Liberia and Filipe Nyusi of Mozambique.

Drawn to the Kenyatta International Convention Centre, the venue of the conference, were some 18,000 participants, including 300 top business executives, 1,700 business representatives from Japan and 2,000 from Africa.

Japan's Prime Minister Shinzo Abe flanked by African leaders at TICAD-VI. Rwandan Presidency

Setting the tone

TICAD, organized by the Japanese government, the UN's Office of the Special Adviser on Africa, the UN Development Programme, the African Union (AU) and the World Bank, this year held its first session on the African continent since it was launched in 1993. In response to pressure from African participants, meetings will from now on be held every three years instead of every five years, with alternate hosting by Japan and Africa.

As with all previous five events, leaders used this year's TICAD to deliberate on Africa's socio-economic development, using the yardsticks of the Sustainable Development Goals and Agenda 2063, a set of aspirations adopted by African leaders to transform the continent.

Prime Minister Abe set the tone in his opening address: "Africa is now up and running, aiming at long-range goals, aspiring to be a certain kind of continent with certain kinds of countries in 2063."

In addition to agriculture and infrastructure development, participants said improved trade can boost Africa's industrialization. The 77 Japanese companies whose leaders accompanied Mr. Abe to Nairobi were big and not-so-big corporations, indicating an attempt to connect with Africa at varying levels of trade and investment.

"These are firms which are passionate about Africa," Mr. Abe stated. "I hope my visit will boost bilateral relations with Kenya and Africa."

Friendship and trade

The two-day event was as much a jamboree as it was a marketplace of ideas. Companies set up tents to advertise products and services even as political and business leaders were busy canvassing their individual country's attractiveness to foreign investments. But it was the announcement of Japan's commitment to mobilize $30 billion for Africa's infrastructure, health care system and security that grabbed the headlines.

There was also a package to train or "empower" up to 10 million Africans over the next three years, including 1,500 experts under Japan's African Business Education Initiative for Youth (ABE Initiative), and an additional 30,000 engineers by 2018 to support "the foundations of industry," said Mr. Abe.

Participants considered three priority areas for Africa's development. The first is economic diversification and industrialization, which require investments in roads, ports, energy and food value chains. The second is building a resilient health system, an issue that gained urgency following the 2014 Ebola outbreak and the inability of the health systems of Guinea, Liberia and Sierra Leone to respond to the epidemic.

And finally, achieving social stability, which will require leaders to tackle socio-economic instability and climate change disasters through jobs creation for women and youth, disaster risk management and

others. The hope is that economic stability will diminish the propensity for armed insurrections.

While maintaining that Japan will not let up on supporting efforts to "resolve the issues facing Africa" such as insecurity and the plunge in commodity prices, Mr. Abe also underlined the fact that Japan's relationship with Africa is not one-way traffic in which only one partner benefits.

"We have a feeling in our gut that in Africa, where possibilities abound, Japan can grow vigorously. Japanese companies can grow vigorously." Despite current economic problems, experts believe the continent's abundant natural resources, growing population and rising middle class offer good investment opportunities for Japan's companies.

Japan currently has a balance-of-trade advantage over Africa. In 2015 its exports to Africa were valued at $11.6 billion, while imports were valued at $8.5 billion, according to the Japan External Trade Organization. Rich countries need to trade more with developing countries, advised President Kenyatta.

Infrastructure plan

President Kenyatta welcomed Mr. Abe's announcement that $10 billion of the expected $30 billion would be injected into a three-year African Infrastructure Plan targeting projects in education, energy, urban transport (roads and ports), health, agriculture and others. The funds will be channeled through the African Development Bank (AfDB) to boost Africa's electricity generation by 2,000 megawatts and connect 3 million homes to electricity by 2022.

Japan and the AfDB have a long-standing relationship. Between 2005 and 2014, Japan, under its Enhanced Private Sector Assistance for Africa programme, announced sums totaling $3 billion for the AfDB to support sovereign co-financing of projects in agriculture, water, health and infrastructure. Examples of such successfully executed projects are the Bujagali hydropower plant in Uganda, the Sahanivotry hydropower plant in Madagascar, the Lekki toll road in Nigeria and the Takoradi II gas-fired plant in Ghana.

While its engaging with AfDB indicates a strategy of partnering with pan-African institutions to implement projects, Japan is also dealing directly with individual countries, such as by providing Egypt with a $451 million loan earlier this year for the construction of the Grand Egyptian Museum.

At TICAD VI, a total of 73 agreements were signed in what was dubbed the "Nairobi Declaration." Some of the bigger deals include the signing of an agreement between the AfDB and Sumitomo Mitsui Banking Corporation to promote Africa's economic development. Both institutions will cooperate to provide finance for trade as well as for industrial and infrastructural projects and efforts to mitigate trade risks.

Japanese companies are interested in Africa's green energy, agriculture, automobile, motorcycle, textiles, finance and service-sector projects. Toyota Tsusho is developing geothermal energy generation at Olkaria II plant in Naivasha, northwest of Nairobi. The company is also involved in fertilizer production in other countries. Toshiba Corporation, an electronics and energy firm, signed an agreement with Kenya Power and Lighting Company on a project that will cut power distribution losses in the national grid.

Business-friendly environment

President Kenyatta expressed Kenya's readiness to "support partnerships that will ensure that our youth not only get quality jobs but our farmers can also earn more from their sweat and at least 90% of their agricultural exports are processed locally."

Some experts say Japan could have done more for Africa, considering that in May 2015 the country announced a commitment of $110 billion to develop infrastructure in Asian countries. But African leaders generally lauded the goals of TICAD and Japan's relations with Africa, which they viewed as respectful. They want homegrown solutions to Africa's problems. Rwanda's Paul Kagame said, "Modernity does not mean importing values; it means improving your own values," underscoring the need for partners to support Africa's initiatives.

Mozambique's President Filipe Nyusi envisioned "the construction of the economic and financial independence of our continent."

Nigeria's presidential spokesman Garba Shehu said President Buhari wooed new investors and extracted commitments from existing ones, including Honda Motor Company, Mitsubishi Corporation, Toyota Tsusho, and West African Seasoning Company, to expand operations in the country.

Despite African countries' depiction of their continent as ready for investments, Prime Minister Abe and his entourage continued to stress the need to strengthen a more business-friendly environment. Mr. Shehu interpreted that as an indirect reference to "the problem of insecurity." Nigeria is battling Boko Haram insurgents, and across the border from Kenya is Somalia, where the Al-Shabaab rebels continue to wreak havoc, sometimes inside Kenyan territory.

At the summit, Chadian president and AU chairperson Idriss Déby called on Japan and other partners to contribute to the AU counter-terrorism fund.

Experts suggest that a business-friendly environment also means stable economic and trade policies and reliable infrastructure, which many African countries lack. Nevertheless, Tomohiko Taniguchi, a special adviser to the Japanese government, says "otherwise risk-averse Japanese companies have finally come to be aware that Africa can provide them with real growth opportunities."

A highlight of TICAD VI was the launch of the Japan-Africa Public and Private Economic Forum, which is expected to serve as a platform for forging business ties between governments and corporations. The forum will bring the "power of the public and the private sectors together to forge solutions," said Mr. Abe, adding that Japanese cabinet members and top business executives will visit Africa every three years to meet with African companies to identify "what needs to be done to enable Japanese and African companies to do more business together going forward."

For its African beneficiaries, TICAD VI was a shot in the arm. President Jacob Zuma, representing South Africa, Japan's largest trading partner, said that what is now needed is for Japanese investments "to be structured in a way that all [African] countries are able to benefit, particularly when it comes to bigger projects." That's a view that will cheer leaders of Africa's smaller economies.

The next TICAD will be held in 2019 in Tokyo and should be one more opportunity to take stock of progress made since the Nairobi Declaration.

Morocco flexes economic muscles as it seeks AU reinstatement

The North African country seeks to leverage its economic weight in sub-Saharan Africa

BY **FRANCK KUWONU**

Moroccan King Mohammed VI is welcomed by President John Pombe Magufuli on a visit to Tanzania in October 2016. *Presidency of Tanzania*

Slowly and steadily, Morocco has been establishing itself as a major economic force in sub-Saharan Africa, even as it eyes gaining readmission into the African Union (AU), which it left decades ago.

Last July, King Mohammed VI of Morocco informed African leaders attending the AU summit in Kigali, Rwanda, of his country's wish to return to the fold, saying, "Morocco should not remain outside its African institutional family, and it should regain its natural, rightful place within the AU."

Two months later the kingdom formally submitted a request to re-join the continental body, thus starting a process that may lead to its readmission at the next AU summit in Addis Ababa in January 2017.

Morocco left the former Organisation of African Unity (AU's predecessor) in 1984, to protest the seating of the Polisario Front as representatives of the Sahrawi Arab Democratic Republic (SADR), a former Spanish colony west of the Sahara that Morocco considers part of its territory. SADR disputes Morocco's position, and 30 years later the dispute remains unresolved.

In explaining Morocco's current decision to join the AU, the king said, "When a body is sick, it is treated more effectively from the inside than from the outside."

The kingdom has expanded its economic ties with many countries on the continent, mainly through trade and investments since it left the AU. It now seeks to return to the fold, boost these ties and settle the unresolved Western Sahara matter.

Continental ambition

"We are Arabs, but we are also Berbers and Maghrebi," Brahim Fassi Fihri, the president and founder of Institut Amadeus, a Morocco-based think tank, told *Africa Renewal*.

He was referring to the multicultural identity of his country, which is made up of mostly Berber and Maghrebi ethnic groups. He maintains that the decision by Morocco to leave the regional body three decades ago was a "strategic mistake." Still, "Africa is our natural home," he said. "We may have left an organization, but we could never have left the continent."

As a sign of its political solidarity with Africa, Morocco's national carrier, Royal Air Maroc, maintained its regular schedule to West Africa at the height of the Ebola

epidemic two years ago, when all international air carriers, with the exception of Belgium-based SN Brussels, suspended flights to the affected countries of Guinea, Liberia and Sierra Leone over contagion fears.

The decision was based on humanitarian grounds, not commercial—out of brotherly solidarity "reflecting the kingdom's constant commitment to Africa," the airline's spokesman told Agence France-presse (AFP) at that time.

The airline has expanded its network across the continent. Over the past decade, it has increased its flights to African destinations from 14 in 2007 to 32 in 2016.

To some extent the story of the national carrier is a telling testament to its expansive economic ambition on the continent.

Over the 10-year period starting in 2004, Morocco's trade with the rest of the continent grew by an annual average of 13% ($3.7 billion) in 2014, 42% of which was with sub-Saharan Africa. This represented just 6.4% of the kingdom's overall trade globally during the same period, according to a government report titled *Morocco-Africa Relationship: Ambition for a New Frontier*.

First investor in West Africa

Yet the most remarkable change was Morocco's direct investments in the continent. In 2015 it invested $600 million, with neighbouring Mali getting the lion's share, followed by Côte d'Ivoire, Burkina Faso, Senegal and Gabon, according to the *World Investment Report 2016*, a publication of the United Nations Conference on Trade and Development (UNCTAD).

Over the decade ending in 2016, Morocco's investment in sub-Saharan Africa represented 85% of its overall foreign direct investment (FDI) stocks, according to data from the country's finance ministry and the African Development Bank.

"Moroccans became a more prominent investor on the continent, initiating 13 intra-Africân investments—its highest in over a decade," reckoned a 2015 survey report by Ernst & Young, a global financial consultancy firm.

The reason behind the growing interest in sub-Saharan Africa, says Ernst & Young, was that "Moroccan companies are looking towards sub-Saharan Africa as their country becomes a platform for exporting to other African countries."

Morocco's investments are mostly concentrated in banking and telecommunications sectors, which in 2013 accounted for 88% of its FDI stocks in sub-Saharan Africa.

The country's leading bank, the Attijariwafa Bank Group, and part of the kingdom's holding company Société nationale d'investissement (SNI), with 7.4 million customers and more than 16,000 employees, operates in 10 sub-Saharan African countries: Cameroon, Republic of Congo, Côte d'Ivoire, Gabon, Guinea-Bissau, Mali, Mauritania, Niger, Senegal, and Togo.

The Banque Marocaine du Commerce Extérieur (BMCE) group has a network of 18 country operations, mostly in West, Central and East Africa through Bank of Africa, its subsidiary. Maroc Telecom, the leading national telephone company, operates in 11 African countries, such as Burkina Faso and Mali, under different names, including Moov in francophone West Africa.

Preferred destination

Beyond these traditional sectors, Moroccan companies have also ventured into insurance. The Saham Insurance Group, for one, began operations in 10 African countries in 2010, and continues to expand across the continent, most recently with the acquisition in 2015 of Continental Reinsurance Plc of Nigeria.

For many years West African countries and to some extent Central African countries were the preferred destinations of Morocco's investment in sub-Saharan Africa. In his letter to the AU, the king explained that "the important involvement of Moroccan operators and their strong engagement in the areas of banking, insurance, air transport, telecommunications and housing are such that the kingdom is now the number one investor in West Africa." He added, "My country is already the second largest investor on the continent and our ambition is to be ranked first."

Last October the king travelled to East Africa and Ethiopia, as Rwanda and Tanzania prepared to sign business deals. "The Moroccans' current visit to East Africa marks a serious intent to enter the region and widen their interests in Africa," *The New Times* in Rwanda reckoned.

To some observers the reasons behind Morocco's foray into the continent are purely economic. "Several Moroccan companies are betting their growth on sub-Saharan Africa," says Mr. Fihri. He told *Africa Renewal* that Moroccans, just like Americans, Europeans and Asians, are interested in Africa because it is "a continent with huge growth potential."

In September 2015, Abdelmalek Alaoui, a Moroccan editorialist and political analyst, wrote in *La Tribune*, a French weekly financial newspaper, "Well ahead of other investors [before the latest rush on the continent], Morocco was able to see potential where others could only think of risks."

Political leverage

However, other analysts like Amine Dafir argue that Morocco's growing economic interest on the continent was designed to shore up influence it may have lost by withdrawing from the AU.

Supporting Morocco in its application to rejoin the AU is a group of 28 African countries, representing more than the half of the votes (27) required for admission. The pro-admission countries penned a letter to the AU requesting the suspension of SADR's membership until issues surrounding the legality of its existence are resolved by the United Nations Security Council. "Our demand is grounded in international laws," says Macky Sall, the Senegalese president, whose country is one of the signatories.

Over the last three years, the king of Morocco, often travelling with a large entourage of businessmen, has visited several African countries, including Côte d'Ivoire, Gabon, Guinea-Bissau, Mali and Senegal. Besides being the most vocal supporters of the kingdom, these countries are also the top five destinations of Morocco's FDI in sub-Saharan Africa.

In November, the king hosted a gathering of 30 African leaders in the margins of the climate change summit in the Moroccan city of Marrakesh, to "coordinate [African countries'] positions and speak with one voice to defend them," a senior Moroccan diplomat told the AFP, a French news agency. The AFP pointed out that hosting the summit was a diplomatic coup for the kingdom as it sought to reassert its influence in Africa.

As Morocco pursues moves to have its AU membership reinstated, Jawad Kerdoudi, the head of the Moroccan Institute of International Relations, sees these efforts as a "diplomatic victory born out of a deliberate and actions-driven strategy".

New business opportunities through government tenders

African companies to bid for contracts around the world

BY **DOYEUN KIM**

Roadworkers undertaking repairs on a World Bank funded road. World Bank/Trevor Samson

Public procurement is fast becoming big business in Africa. It accounts for almost a third of the gross domestic product (GDP) in poor countries and up to 15% in developed countries.

In some countries, the share of public procurement, which is the purchase of goods, works or services by government or public institutions, is more than half of government expenditures, according the International Trade Centre, a joint agency of the World Trade Organization and the UN Conference on Trade and Development.

To encourage more private companies in Africa to participate in bidding these contracts, the United Nations Development Business (UNDB)—the official online platform for information on procurement projects and contracts financed by multilateral development banks and governments—is expanding plans to raise public awareness of its website for consultancy, contracts and export opportunities available worldwide.

To be considered for contracts offered through the UNDB platform, companies have to register as subscribers on its website where tenders from governments and financial institutions, including the World Bank and the African Development Bank, are published to a global audience.

The platform publishes more than $90 billion worth of contracts each year, giving companies around the world access to business opportunities in the international procurement market. UNDB publishes in English, French, Spanish and Portuguese and has clients in more than 180 countries.

The number of African companies subscribing to the database, however, is still very low—with the exception of companies from South Africa, Nigeria and Kenya—despite the fact that about 30% of the projects published on the platform are in Africa.

Winning a government contract can be an enormous opportunity for any business, so every step of the procurement process can be vulnerable to integrity risks where undue influence, conflicts of interest and fraud may occur. The volume of financial flows involved makes this system one of the most important places to watch for those integrity risks.

For this reason, institutions like the World Bank have come up with strict procurement requirements as a condition for development aid. Transparency in awarding tenders and contracts is crucial to ensuring efficient and accountable use of taxpayers' money. Equally, transparency paves the way toward fair and better competition, which ultimately contributes to the best value for money for public projects.

Recognizing the need for efficiency and more accountability and integrity in the management of public resources, the World Bank has been encouraging procurement reforms since the 1990s in member countries. Internal efforts, as well as assistance from international development agencies, are focusing on professionalizing and building capacity in national procurement systems.

These efforts are consistent with the goals of good governance and prevention of corruption in the use of public funds, and they are also increasingly being linked to the Sustainable Development Goals (SDGs), because public procurement can be used as a tool for achieving and sharing prosperity.

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Africa's high expectations for ...
from page 3

working in 126 countries, providing protection and assistance to over 60 million refugees, returnees, internally displaced persons and stateless persons.

In his leadership position, he oversaw the most profound structural reform process in UNHCR's history, increasing the organization's capacity to respond to some of the largest displacement crises since the end of World War II. The agency's volume of activities tripled, following the introduction of a need-based budgeting approach.

It was also a time when Africa experienced its own displacement crises, in Central African Republic, Chad, the Democratic Republic of Congo, Somalia and South Sudan, among other countries.

Under Mr. Guterres's leadership, UNHCR and its partners assisted thousands of refugees and asylum seekers from these countries by offering them protection and other assistance such as health care, education and vocational training. He mobilized the international community to improve access to shelter, education, health care and other basic needs for returnees.

Going forward

Africa, therefore, expects the world's top diplomat to continue being committed to the active protection of people in African regions afflicted by conflict.

On his May 2015 visit to Somalia and Kenya, while serving as chief of UNHCR, Mr. Guterres held a meeting with local officials, refugees and host communities in Dadaab, one of the world's largest refugee camps.

During this meeting, Mr. Guterres helped broker a repatriation agreement between the two countries that President Uhuru Kenyatta guaranteed would enable voluntary and dignified repatriation of the Somali refugees in Kenya wishing to return to Somalia amid a climate of concerns held by Human Rights Watch and others.

Mr. Guterres has also pledged to protect and empower women and girls as Secretary-General.

In his acceptance speech at the UN General Assembly upon his appointment as Secretary-General, he said, "I have long been aware of the hurdles women face in society, in the family and in the workplace just because of their gender. I have witnessed the violence they are subjected to during conflict, or while fleeing it, just because they are women. I have tried to address this through every public office I have ever held. The protection and the empowerment of women and girls will continue to be a priority commitment for me."

In light of his track record as prime minister and as head of UNHCR, the expectation in Africa is that he will champion policies that enable people to find solutions to the economic development and political challenges facing the continent.

Gains in fight against malaria ...
from page 5

While malaria is no longer the leading cause of death of children under the age of five in Africa (pneumonia is), the disease still threatens the young, killing a child every two minutes, according to non-profit organization Malaria No More. Progress made in African countries has also been uneven.

Algeria, Botswana, Cape Verde, Eritrea and Swaziland have all experienced sharp decreases in malaria cases, while just two countries, the Democratic Republic of the Congo and Nigeria, account for more than 35% of all malaria deaths worldwide. Of these two, Nigeria, Africa's most populous nation, faces greater risk. Some 100,000 Nigerians die from malaria every year, states Malaria Consortium, a non-profit organization fighting the disease.

The Nigerian government has launched a national malaria elimination programme, ramping up the distribution of mosquito nets and access to drug therapies, and expanding a plan for vector management.

Côte d'Ivoire, Mozambique, Tanzania and Uganda also have high incidences of malaria. Countries with swampy terrain and humid weather are fertile breeding grounds for malaria-carrying mosquitoes. In addition, weak public health systems and conflict mean that many patients do not have access to treatment or malaria-prevention tools.

More monitoring and research

Dr. Christian Happi, a leading malaria researcher from Cameroon, says donors and aid groups need to move beyond distributing malaria control tools and focus more on monitoring how they are used.

"Many groups talk about the number of drugs and mosquito nets they have provided. Numbers make a good public relations campaign," Dr. Happi, who specialises in molecular biology and genetics, said in an interview with *Africa Renewal*. "Are we keeping track of how these tools are used? The answer is no."

While more than 1 billion mosquito nets have been distributed in sub-Saharan Africa since 2000, there are doubts about whether people are using them properly. *The New York Times* published a story in 2015 revealing that impoverished fishermen in Mozambique, Nigeria and Zambia were using mosquito nets as makeshift fishing nets.

One of the biggest hindrances to eliminating malaria in Africa is the prevalence of monotherapy, the use of only one drug to fight malaria. Although public health experts have warned that monotherapies can lead to drug resistance in parasites, the practice continues in many countries.

Dr Happi says African countries lack the robust monitoring systems needed to study drug resistance in parasites. "Behaviours of parasites change all the time. We need to collect blood samples and study them periodically. But African countries lack the resources to do this."

Although progress in the fight against malaria in Africa is undeniable, experts insist its leaders should maintain the same determination that has brought recent successes.

Portable ultrasound device to tackle child mortality

BY PAVITHRA RAO AND DONA JOSEPH

At the dispensary, Zaina can get an ultrasound examination, thanks to GE Healthcare's mobile Vscan ultrasound device. GE Sustainability

The puzzle of the high maternal and child mortality rate in Africa, especially for children under the age of five, remains a major concern even as all efforts are made to reverse the trend.

The figures are bleak: 1 in 12 children in sub-Saharan Africa dies before turning 5, and more than 430 women die each day from preventable causes related to pregnancy and childbirth, according to the World Health Organisation (WHO).

Infections related to the delivery process, and communicable diseases such as diarrhoea, pneumonia and malaria, are the leading cause of these deaths. The high number of maternal deaths reflects inequities in access to health services.

To help save lives, some companies have started tapping into new technologies that can diagnose health conditions and diseases more efficiently and accurately than current practices using standard equipment.

One such technology is the Vscan, a non-invasive ultrasound device the size of a smartphone, which provides real-time high-resolution images that can be used in medical fields such as cardiology and obstetrics and gynaecology.

Created by General Electric, a US conglomerate corporation, and launched at the World Health Assembly in Geneva last May, the Vscan, with its handheld size and easy-to-navigate touch screen, can come in handy in rural areas in Africa where health facilities are under-equipped.

The new invention can be a valuable asset in prenatal and antenatal care for mothers who do not have access to larger health care facilities.

WHO recommends that women have at least four antenatal visits to detect any complications in pregnancies, and many in rural areas do not have the means or the access to facilities to undertake even a single visit. One ultrasound scan before 24 weeks' gestation (known as an early ultrasound) is crucial to estimate gestational age, improve detection of fetal anomalies and multiple pregnancies, reduce induction of labour for post-term pregnancy, and improve a woman's pregnancy experience.

A Vscan machine retails for about $10,000, as opposed to the traditional cart ultrasound machine, which can cost $250,000 or more.

The device has been well received, especially by pregnant women and health experts, because it can be instrumental in finding birth defects in foetuses, and can help in monitoring high-risk pregnancies as well as determining the position of a baby before birth.

Towards the end of this year, GE officials travelled to Nigeria to assist more than one thousand midwives and health care providers with training over the course of three years.

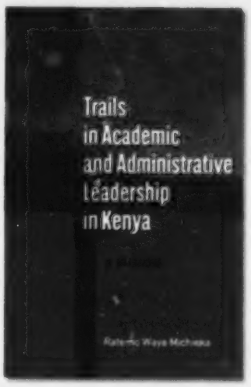
"Through the availability of relevant technologies, such as the Vscan access and comprehensive training, we aim to make a meaningful contribution to primary and referral care by building capacity, enhancing skills and driving better outcomes for Nigerian mothers and babies and for their communities," says Farid Fezoua, the president and CEO of GE Healthcare Africa.

BOOK REVIEW

Trails in Academic and Administrative Leadership in Kenya: A Memoir

by Ratemo Waya Michieka

CODESRIA, Dakar, Senegal, 2016, 320pp



Scholars seeking an understanding of how leadership has inhibited academic freedom and hindered the effectiveness of higher learning institutions in Africa have shown interest in how these institutions are run.

The absence of material documenting the experiences of those who have served as university leaders has created a major gap. This has raised many questions that still remain unanswered particularly on how leaders of higher education institutions are identified, how they are prepared, the personal predispositions they bring to such positions and personal experiences on what energizes or inhibits their performance.

Trails in Academic and Administrative Leadership in Kenya: A Memoir, a book written by a former vice-chancellor of Jomo Kenyatta University of Agriculture and Technology, Ratemo Waya Michieka, tries to answer some of these questions through a skilful weaving of stories of his childhood in rural Kenya to his experience as head of a top public university.

Prof. Michieka details his experiences and struggles within the university system —during the time when Kenya experienced a shift from a government that sought to rigidly control academic standards to one that tried to give them autonomy. The author shares his experience in trying to steer clear from politics while avoiding crises such as declining academic standards and the relevance of curricula that continue to plague universities in Kenya and other countries in sub-Saharan Africa. He also talks about student protests, which many lecturers were arrested for, as they were thought to have prompted rebellious thinking through their teachings.

The author is critical of how heads of higher learning institutions were appointed during the time of former President Daniel arap Moi, noting that although most of them were highly respected scholars, they often lacked leadership and administrative skills and were not given terms of reference. Hence the book's concentration on administration and management of higher learning facilities, as well as transforming such facilities from mediocrity to academically outstanding.

Published by the Council for the Development of Social Science Research in Africa (CODESRIA), the memoir is arranged into 19 chapters. It gives important insights into the extensive changes that were fought for and are now evident in Kenya's academic system, which seeks to find a balance between political pressures and long-standing institutional conventions.

— Pavithra Rao

APPOINTMENTS

UN Photo: Paulo Figueiras

United Nations Secretary-General Ban Ki-moon has appointed **François Louncény Fall** of Guinea as acting Special Representative for Central Africa and Head of the UN Regional Office for Central Africa (UNOCA). Mr. Fall most recently served as vice-chairman of the Joint Monitoring and Evaluation Commission of the South Sudan Peace Agreement. He succeeds Abdoulaye Bathily of Senegal.

UN Photo

Hubert Price of United States has been appointed as Head of the UN Support Office in Somalia (UNSOS). Prior to this appointment, Mr. Price served as director of mission support for the UN Mission in Liberia (UNMIL).

UN Photo / Anne-Laure Lechat

Yagoub El Hillo of Sudan has been appointed as deputy special representative in the UN Mission in Liberia (UNMIL) as well as the United Nations resident coordinator and resident representative of the UN Development Programme (UNDP). Most recently, Mr El Hillo served as the UN resident coordinator, humanitarian coordinator and UNDP resident representative in Syria. He succeeds Antonio Vigilante of Italy.

UNOGBIS

Maria do Valle Ribeiro of Ireland has been appointed as deputy special representative and deputy head of the UN Support Mission in Libya (UNSMIL). Ms. do Valle Ribeiro will also serve as UN resident coordinator, humanitarian coordinator and resident representative of UNDP.

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